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EXPLORING THE EXPERIENCE AND IMPACT OF FORUM THEATRE TECHNIQUES FOR DEVELOPING MENTAL HEALTH NURSING SKILLS: A MIXED METHODS RESEARCH PROJECT

REUBEN PEARCE

A thesis submitted in partial fulfilment of the requirements of the University of West London for the degree of Doctor of Nursing

This research programme was carried out
in collaboration with Berkshire Healthcare NHS Foundation Trust

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Abstract

The purpose of the study was to explore the experience and impact of Forum Theatre techniques for developing mental health nursing skills. There is an emerging body of work that aims to explore and evaluate the use of Forum Theatre as a pedagogy in healthcare education. However, published research on the subject is limited to just a small number of evaluative studies. No primary research has explored the use of Forum Theatre for training mental health nurses. Despite the limitations, review of the literature has established that further exploration of Forum Theatre as a pedagogy in healthcare education is needed.

The aim of the current research was to understand the effectiveness of Forum Theatre techniques on mental health nursing skills by understanding how Forum Theatre was experienced, what specific skills it addressed, and whether these skills impacted on practice. A Pragmatic lens permitted the researcher to encompass the strengths of other methodologies through a two-phase sequential exploratory mixed design.

Phase 1 was qualitative, and the results informed the choice of measure for phase 2, which was quantitative. Phase 1 data collection was via eight semi-structured interviews and thematically analysed using a qualitative descriptive approach. The phase 1 findings revealed that Forum Theatre increased empathy in participants, supported by four themes; learning environment, authenticity, active learning, and personal development, with subthemes; communication, resilience, and empathy.

Phase 2 was designed to measure whether there was a significant difference in participant empathy before and after a standardised Forum Theatre workshop focused on a mental health crisis intervention. The Jefferson Scale of Empathy was used to measure participant empathy pre-post-intervention. A paired samples Wilcoxon test and Kruskal-Wallis test confirmed a significant increase in empathy in 95% of cases, confirming that Forum Theatre techniques increased participant empathy for others.

The significance of this study is in how it informs understanding of Forum Theatre as a learning and teaching strategy for use in mental health nurse education and for developing skills in delivering empathic care in crisis intervention. In addition, a model is provided that illustrates how Forum Theatre can support a cycle of development across the affective, cognitive, and behavioural domains of empathy.

Acknowledgements

First and foremost, I am incredibly grateful to my supervisors, Dr Rowan Myron, Professor Heather Loveday and Dr Sue McLaughlin, their advice, continuous support, and patience over the past several years has been invaluable. Their extensive knowledge and years of experience have encouraged me to continue to believe in myself, and see this journey through to completion. I want to extend this gratitude to Professor Kitrina Douglas for her knowledge, feedback, recommendations, and kindness during the Transfer Viva.

I must acknowledge my utmost appreciation and respect for all students who participated in the study. Without your commitment and valuable insight, the study would never have been able to move forward.

I would also like to thank my brilliant colleagues, Dr Nicki Moone, Dr Gwen Bonner, Dr Claire Anderson, Dr Raja Natarajan, Helen Robson, Aby Mitchell, Catherine Lynch, Trish Earl, and Daren Bailey, for their wisdom, patience, humour, encouragement, and flexibility over the course of the study.

Finally, I would like to express love and gratitude to my close friends, family and parents, Ken and Angela, my wife Louise, my children Josey and Flynn, and our dog Arlo. Without their tremendous understanding, encouragement, and sacrifice, it would have been impossible for me to complete my study. I am going to do all I can to make up for the time lost with you.

Overview of the Thesis

Introduction to the Study

The purpose of the study was to explore the experience and impact of Forum Theatre techniques for developing mental health nursing skills to support people experiencing emotional distress. It aimed to understand the meanings that mental health nurses have attributed to their experiences in relation to a workshop that employs Forum Theatre techniques. Using an exploratory sequential mixed methods study design enabled development of understanding and capture of impact on how Forum Theatre has influenced participant's knowledge, skills, and behaviours. The knowledge developed through the course of the study demonstrates the validity of Forum Theatre as a learning and teaching strategy for use in mental health nursing. The study created insight into the essence of the phenomena, generating new ideas and modifying existing theories by combining interpretivist and post-positivist approaches. The study contributes to the knowledge gap on the mechanisms through which a theatre-based intervention can enhance social and cognitive skills required in effective mental health nursing.

Guide to Chapters

Chapter 1: Context of the Study

This chapter introduces the key concepts that underpin, frame, and position the study of Forum Theatre in relation to mental health nursing education and practice. The chapter first explores the origins and techniques of forum theatre and consider these in relation to learning theory. The role of the mental health nurse in practice is provided, including current issues and challenges. The chapter concludes with how Forum Theatre can be used as a pedagogy to prepare mental health nurses to face the challenges in contemporary practice.

Chapter 2: Literature Review

Chapter two provides a systematically conducted review of the literature. The chapter first sets out a rationale clear objective and identifies questions for the review. A search strategy is provided that includes the eligibility criteria and demonstrates the process for selecting articles. The results are provided with the process used for quality appraisal and synthesis to demonstrate how the themes were generated. The key themes are discussed and used to generate the research aim, questions, and objectives for the study.

Chapter 3: Methodology

The methodology chapter begins by providing detailed discussion of the ontological and epistemological assumptions that underpin the study, and justification for a mixed methods approach to answering the research questions. The chapter then provides details of the research design and procedures including sample and recruitment, data collection, data analysis, validity, trustworthiness, and ethical considerations.

Chapter 4: Analysis and Results

The analysis and results chapter provides an account of the how the analysis was conducted over qualitative and quantitative phases. The chapter presents the analysis and results in sequence and concludes with the mixed method results being presented in a joint display.

Chapter 5: Discussion

The discussion explores the meaning, importance, and relevance of the findings. The focus is to explain and evaluate the findings and demonstrate how they relate to the literature and research questions to make an argument in support of the overall conclusion. The discussion

begins by providing a model built through synthesis of the findings and explores the main themes, their patterns, principles, and relationships that contribute to the overall conclusion.

Chapter 6: Conclusion

The conclusion provides a recapitulation of the research with a summary of the major findings provided, relationship with the previous research and limitations. Implications for mental health nurse education and practice are explored, with recommendations made for future action, policy, and research. A summary of impact on practice from the accompanying portfolio of impact is provided before final reflections conclude the chapter and thesis.

Reflexive Notes

At the end of each chapter extract field notes are provided, taken from a reflective insight into the researcher's personal growth through prospective, retrospective reflection and also evaluation processes. These demonstrate an awareness of how the researcher's own values, opinions and experiences can be positive and can inform the study but need to be considered in relation to researcher bias. This process allowed the researcher to consider how the study process has impacted on himself and consider this in the context of subsequent steps.

Introduction to the Researcher

I am a registered mental health nurse, currently working as a Nurse Consultant for Crisis Resolution and Home Treatment Services in the National Health Service. My interest in education and specifically Forum Theatre came in 2008. During this time, I had become more involved in teaching activities for nursing staff and began working with a psychiatrist who had similar interests and a group of skilled actors. We were using various interactive theatre techniques to develop communication skills for healthcare staff. I saw real benefits in

interactive theatre for improving communication skills, and it was during this period that I moved to teaching at the University of West London. The university embraced new ideas, allowing me to use interactive theatre across a range of nursing courses and therefore this became the focus of my professional doctorate.

Since I returned to practice in 2019, I have continued to develop Forum Theatre techniques for skills development of mental health practitioners including during the Covid 19 pandemic, where we adapted Forum Theatre for online use as a meaningful way of engaging staff in learning through a very challenge period.

Forum Theatre workshop with 2nd year mental health nursing students

(University of West London, 2018)

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Chapter 1 Context of the Study

1.1 Introduction

This chapter introduces the key concepts that underpin, frame, and position the study of Forum Theatre in relation to mental health nursing education and practice. The chapter first explores the origins and techniques of Forum Theatre and considers these in relation to learning theory. The role of the mental health nurse in practice is provided including current issues and challenges. The chapter concludes with how Forum Theatre may be used as a pedagogy to prepare mental health nurses to face the challenges in contemporary practice.

1.2 Rationale for the study

Good communication is central to providing quality mental health services that meet the needs of a diverse and growing population. Ineffective communication impacts significantly upon service users, carers, staff, and other public services. This can lead to poor outcomes for patient care and cohesive team working such as disengagement, disempowerment, distress, misinterpretation, and poor impressions. This can all have a fundamental impact on patient safety and staff wellbeing (Kanel, 2019).

While traditional teaching methods can highlight the 'do's' and 'don'ts' of communicating with others they may not provide the opportunity for learners to explore in depth the attitudes, beliefs and behaviours that can influence their own interactions (Middlewick *et al*, 2012). The acquirement of knowledge through lived experience can facilitate deeper learning than didactic teaching methods (Kolb, 1984; Vygotsky, 1978). Issues that arise from communication

challenges in practice can be better navigated and managed through increased self-awareness and the skills of reflecting 'in' action (Schon, 1988).

It may be argued that experiential learning, utilizing Forum Theatre techniques, creates a deeper level of learning through active participation of learners using their knowledge to problem solve and find solutions to practice dilemmas (Mclaughlin, Pearce and Trenoweth, 2013). Furthermore, learners may develop the emotional resilience required to feel confident in communicating across a range of difficult situations that are common in mental health nursing practice. The use of professional actors in Forum Theatre may provide a safe environment to try out interactions without risk to patient safety (McClimens and Scott, 2007).

The emancipatory underpinnings of Forum Theatre and constructivist learning theory are inherent in its approach (Boal, 1974) and combine well with the aims of developing highly skilled reflective mental health nurses. It may help with developing emotional resilience and skills in effective communication with service users, families, and carers. In recent years there has been a growing interest in the use of role-play and Forum Theatre techniques for communication skills training in healthcare, however, there was currently no literature that specifically explores Forum Theatre techniques in developing mental health nursing skills (Chapter 2, section 2.8).

Finally, bolstering the issues discussed has been the socio-political-economic backdrop. In recent years there have been unparalleled pressures on healthcare services (Cummins, 2018) compounded by the Covid-19 pandemic (Hotopf *et al*, 2020). These pressures have had a huge impact on staff and resulted in low morale and burn-out, with implications for patient safety and quality (Sinyor *et al*, 2021). The evidence base in terms of leadership, services, best

practice and the national agenda for health are often an oxymoron to financial resources offered to meet the agenda and conflicting political ideologies modelled by government (Cummins, 2018).

While addressing all the challenges of the health service is clearly not the aim of this project it is hoped that the work undertaken might play a tiny part in establishing how a Forum Theatre workshop might be useful in helping mental health nurses improve their practice in supporting people experiencing mental health crisis.

While Forum Theatre has a well-known and firm theoretical basis, it's application in practice, particularly in mental health nursing, has not been explored in depth. Given that a long-term objective in the Nursing and Midwifery Council's educational agenda has been to reduce the theory-practice gap, it is evident that this study could contribute to the body of knowledge in addressing this gap (Greenway, Butt and Walthall, 2019). The following sections provide more background on the different concepts that underpinned the study.

1.3 Concept of Forum Theatre

1.3.1 Origins of Forum Theatre

Forum Theatre is a form of developmental theatre used as a technique to create societal change by engaging and liberating individuals and communities from oppression (Campbell, 2019). Forum Theatre is part of a group of theatrical techniques called 'Theatre of the Oppressed' developed by Brazilian theatre practitioner, drama theorist and political activist, Augusto Boal in the early 1970s (Boal, 2000). Boal developed Theatre of the Oppressed during his work with peasant and worker populations in Latin America in the 1960s, these techniques are now

used all over the world for social and political activism, conflict resolution, community building, therapy, and government legislation (Miramonti, 2017). Theatre of the Oppressed techniques are also practiced on a grassroots level by community organizers, activists, teachers, social workers, and cultural animators (Prentki, 2015). Underpinned by social justice and transformational philosophies, Boal believed that Forum Theatre would help communities understand their oppression and empower them to do something to address it (Boal, 2000).

1.3.2 The techniques used in Forum Theatre

Forum Theatre can be seen as a problem-solving technique in which an unresolved scene of oppression is presented in a live play (Boal, 2006). The action is then replayed with live participation from the audience who are invited to stop the action, replace the character they feel is oppressed, struggling, or lacking power, and improvise alternative solutions (Rae, 2013). By assuming the role of a 'SpectActor' audience members can rehearse real-life situations in a safe, simulated environment (Coulter, 2018).

The SpectActor is the term used by Boal to describe the active spectator, the audience member who takes part in the action. SpectActors can provide answers and solutions to problems being shown to them by either suggesting or even replacing one of the actors on the stage area and acting their own ideas (Boal, 2000). SpectActors get the opportunity to shape their own thinking, feelings, reflections, and creative solutions to the challenges encountered from their narratives (Boal, 2000).

The Forum Theatre performance is mediated by a figure known as 'The Joker'. The Joker may 'stop and start' the performance offering other participants the opportunity to take part, offer suggestions or ask the actor (who remains in role) questions about their responses (Epskamp

and Epskamp, 2006). The situation can evolve in different ways ultimately resulting in more positive outcomes (Dwyer, 2004). This structure can be used to explore past and current situations, or as a rehearsal for the future (Plastow, 2009).

Forum Theatre is described by Boal (2000) as a platform which enables people to change their perceptions and view of the world. The workshop guide and actor brief (Appendix 1) outlines the format used for Forum Theatre in this study and the written information given to the actor as part of their preparation for the role of a patient.

1.3.3 Forum Theatre and constructivist learning theory

Although Forum Theatre is built upon transformative philosophy it can be argued that the way in which individuals learn during a Forum Theatre exercise aligns with the constructivist theory (Braund, 2015). Constructivism is a theory of learning suggesting that learners create their own knowledge of the topics they study rather than receiving that knowledge from another (Fostnot, 2013). According to constructivist learning theory, the four aspects of constructivist teaching sessions include: learners construct their own meaning, new learning builds on prior knowledge, learning is enhanced by social interaction and meaningful learning develops through authentic tasks (Bruner, 1966; Proctor, 2019).

There are two basic versions of the constructivist approach: cognitive and social constructivism, which were respectively developed by Jean Piaget (2013) and Lev Vygotsky (2007). Cognitive constructivism focuses on individual internal construction of knowledge (Wadsworth, 1996) while social constructivism suggests that learners first construct knowledge in a social context and then individually internalize it (Vygotsky, 1978).

The constructivist approach promotes critical thinking and creates motivated and independent learners (Simpson, Jackson and Simpson, 2004). It is based on the belief that learning occurs as students are actively involved in the process of knowledge construction and meaning, instead of passively receiving information (Wadsworth, 1996). Educators use constructivist approaches to structure their teaching in ways that allow for a democratic environment, interactive/student-centred activities, and actively involved learners who are responsible and autonomous (Aubrey and Riley, 2018).

1.4 Contemporary issues facing Mental Health Nurses

1.4.1 Mental health nursing and recovery focused practice

Mental health nurses support and provide care to people experiencing emotional distress, irrespective of a formal diagnosis of a mental illness or disorder (Barker, 2017). They support colleagues to better meet individual need across the life course, from children and adolescents to adults and older people, delivering a range of mental healthcare in a variety of settings (Evans, Nizette and O'Brian, 2019).

The experience of receiving a mental health diagnosis can lead to feelings of being oppressed, devalued, and marginalized in society. People suffering with mental illness have described an experience of dehumanization often created by mental health services (Walsh, 2017). Reflecting on this, it is possible see how there is a concept of 'surviving the system' that has grown within service user networks (Rethink, 2018). This presents challenges to mental health nurses as the profession associates itself with being caring, person-centred and compassionate rather than being part of an oppressive system that devalues people (Huggett *et al*, 2018).

Recovery is a uniquely individual and deeply personal journey. The principles of recovery are based on the belief that people have their own natural capacity for change and that it is possible to recover from mental health conditions (Slade, Oades and Jarden, 2017). Unfortunately, mental health services continue to be designed with a view of mental health issues that are long-term and progressive (Elison *et al*, 2018). Recovery-focused mental health nursing can only be actualised if nurses are self-aware and able to reflect on their own personal understanding of recovery and well-being (Harris and Panozzo, 2019).

1.4.2 The role of the therapeutic relationship in recovery focused care

The therapeutic relationship is viewed as an essential part of mental health nursing care and supporting recovery (Clarkson, 2003; Harris and Panozzo, 2019). Carl Rogers and other humanistic theorists emphasised the role of the therapeutic relationship as a platform, upon which the therapist could create a constructive, respectful, non-judgmental environment (Hewit and Coffey, 2005; Rogers, 1986; Scanlon, 2006). Demonstration of genuineness, empathy, and unconditional positive regard towards the patient, can facilitate the conditions that enable individuals to find their own solutions to the difficulties they face (Stanley and Jubb-Shanley, 2007). Mental health nursing innovator Hildegard Peplau drew upon these various conceptualizations to establish the concept of the therapeutic relationship as a cornerstone of mental health nursing practice (Winship *et al*, 2009).

Providing a clear framework for the therapeutic relationship, the qualities and skills needed, and the process utilied are essential for mental health nurses to develop the capability and confidence to initiate, build and sustain relationships with patients. There is a growing body of evidence through feedback on the patient experience to suggest that in some cases

therapeutic relationships are not being developed and nurtured to a good enough standard in clinical practice (Gilburt, Rose and Slade, 2008; Gray, 2019; Howard *et al*, 2020; Sweeney *et al*, 2014).

The presence of a therapeutic relationship ensures that patients can make full and effective use of the expertise, knowledge, skills, and human contact offered by nurses, experiencing positive psychological benefits such as a sense of worth, empathy, respect, and developing agency through being a partner in a relationship that is characterized by acceptance and trust (Flaskas *et al*, 2018)

Patients consistently identify high satisfaction in their care and treatment where a therapeutic relationship has been established (Cahill, Paley, Hardy, 2013; Wyder *et al*, 2015). Furthermore, nurses value their ability to form positive therapeutic relationships (McAndrew *et al*, 2014). The absence of a therapeutic relationship can hamper the planning and provision of the care and treatment that enables and enhances recovery. This may lead to disengagement with services (Sampaio *et al*, 2015) In broad terms, the therapeutic relationship has been conceptualized as both the cause of change as well as the vehicle for change, and the active engagement of patients in their care and treatment is seen as central to achieving successful outcomes and recovery (Wiener, 2009).

1.4.3 Empathy in the therapeutic relationship

Empathy as a therapeutic tool has its origins in the work of Carl Rogers (1961) who described empathy as a "state of perceiving the internal frame of reference of another person, with accuracy and with emotional components and meanings that pertain to it, 'as if' one were with

the other person, but without the loss of the 'as-if' condition" (Rogers 1975, p.140). Rogers saw empathy as a core of his person-centred approach to counselling.

The use of empathy has been well documented throughout the health professions as a primary function for patient engagement (Fields *et al* 2011; Jeffery, 2016; Wilkinson *et al*, 2017). Engaging patients is seen as a critical part of interpersonal relations in nursing (Peplau, 1991) with empathy being described as a fundamental to the development of the therapeutic relationship (Rogers, 1986). Kalish (1971) suggests that empathy was the most important component of such a relationship.

In mental health nursing practice empathy is argued as being critical to successful therapeutic relationships (Peplau, 1997; Morse *et al*. 1992; Reynolds and Scott, 2000). Empathy is required for mental health nursing nurses to understand patient distress and then be able to deliver meaningful supportive interpersonal communication. When mental health nurses can effectively communicate understanding and anticipation of their needs, patients will feel more valued (Gerace, 2020).

1.4.4 Working with self-harm and suicide

One of the most challenging and emotive areas of mental health nursing practice is suicide prevention, managing risk and working with patients to develop alternative coping strategies and reduce self-harm to aid recovery (Bell, 2021). The UK has one of the highest rates of self-harm in Europe at approximately 400 in every 100,000. At least 200,000 presentations to general hospitals in England and Wales follow an episode of self-injury or self-poisoning, and people with current mental health problems are 20 times more likely to report previous self-harm in their past (Mental Health Foundation, 2019).

Self-harm is an umbrella term used to describe a wide range of behaviours (Bradvik, 2018). The 2011 National Institute for Clinical Excellence (NICE) guidelines on longer-term management of self-harm provide the following definition: “any act of self-poisoning or self-injury carried out by an individual irrespective of motivation. This commonly involves self-poisoning with medication or self-injury with cutting” (NICE, 2011, p.4). The guideline provides a relatively narrow definition to be clear about to whom the recommendations apply, and excludes accidental harm to oneself, harm through excessive alcohol or drug use, and harm through starving or binge eating associated with eating disorders.

The most significant difference between suicide and self-harm is the intent. People engaging in self-harm usually do so to cope with their feelings and stressors. (Townsend, 2019). For some the self-injury reassures them that they are still in fact, alive especially when they are experiencing emotional numbness or a disconnect from the world (Turner *et al*, 2020). People who are suicidal are more likely to be experiencing severe life stressors and/or mental health disorders that are causing unbearable pain and suicide is their way to end this pain. (Bell and Waters, 2018). Suicide attempts usually come from a place of despair, hopelessness, and worthlessness (Marchant *et al*, 2017).

Thousands of people in the UK end their lives by suicide each year with the most recent statistics suggesting nearly 6,507 suicides occurred in the UK in 2018 (Mental Health Foundation, 2019). That figure means there is one death by suicide every two hours - and many more people are thought to attempt ending their life.

Suicide is the leading cause of death among young people aged 20-34 years in the UK and it is considerably higher in men, with around three times as many men dying compared to women (Office for National Statistics, 2019). It is the leading cause of death for men under 50 in the UK. Those at highest risk are men aged between 40 and 44 years who have a rate of 24.1 deaths per 100,000 population (Office for National Statistics, 2019). The statistics highlight that talking about suicide is still highly stigmatised.

1.4.5 Mental health and suicide risk

People with a diagnosed mental health condition are shown to be at a higher risk of dying by suicide (Bradvik, 2018), with more than 90% of suicides and non-fatal suicide attempts having been found to be associated with mental health disorders. Across the world, the highest rates of suicide are associated with depression (Chesney *et al*, 2014). Studies have found the experience of stressful life events to be associated with depressive symptoms and the onset of major depression (Beghi *et al*, 2013; Hawton, Zahl and Weatherall, 2003) as well as suicide and suicidal thoughts (Skegg, 2005). Previous suicide attempts and engagement in self-harming behaviours are also an indication of particular risk (HM Government, 2019). Up to 16% of survivors try again within a year with 2% of repeat attempts being fatal (DOH, 2017).

The World Health Organisation (WHO) recognises suicide as a public health priority and believe that suicides are preventable (WHO, 2019). WHO support a number of measures that can be taken at population, sub-population and individual level to prevent suicide. The role of mental health nursing is crucial in achieving a number of these measures such as early identification, treatment, and care of people with mental and substance misuse disorders, chronic pain, and acute emotional distress. (DOH, 2017). They also play a huge role in follow-

up care for people who attempted suicide and the provision of community support (Norman and Ryrie, 2018).

1.4.6 Emotional impact of self-harm and suicide on practice

Supporting people who self-harm or experience thoughts of suicide can be very emotive and sometimes lead to judgemental thoughts and disengaging actions (Raynar *et al*, 2019). There is a risk of creating barriers in care and people who self-harm or have suicidal thoughts simply become a risk to be assessed and managed. The result of this is nursing interventions can become automated and task-orientated, and patients become people to be rated or measured (Norman and Ryrie, 2018). Mental health nursing practice may even become more restrictive and rigid through fear of risk and result in patients feeling dehumanized, reinforcing low self-worth (Just, Palmier-Claus and Tai, 2021). Nurses may want to distance themselves from the suicidal feeling or desire to harm oneself, but they need to find a way to tolerate and manage these feelings of anxiety to be able to support the person in their care (Hawton *et al*, 2016).

1.4.7 Just culture

Patient death is one of the biggest fears of mental health nurses (Awenat *et al*, 2017; Baile & Walters, 2013) and while there is a big emphasis on shared learning from serious incidents there remains a deep anxiety of repercussions from perceived failure (Just, Palmier-Claus and Tai, 2021). This fear can impede the concept of a safe environment (Quinlivan, 2020, Tingle, 2020). Reducing perceived threats of humiliation, unhelpful criticism, and fear of making mistakes generates an openness to learning (Edmondson, 2018).

The emotional impact of suicide and self-harm in mental health nursing practice can be compounded by blame culture (Wise, 2018). The blame culture in healthcare has been well documented (Glasper, 2016; Tingle, 2021) and there have been great strides towards a 'just culture' that considers wider systemic issues when things go wrong. This is to enable professionals to learn without fear of retribution (NHS Improvement, 2018).

Despite the progress made in taking a systems approach to investigating incidents, a perception of being blamed or targeted because of a serious incident is still highly prominent in mental health settings (Turner *et al*, 2020). The loss of a patient to suicide is difficult to process, and despite what post incident support is provided, mental health nurses can be left with self-doubt, confusion, guilt and anger (Sandford *et al*, 2020). The internal self-critic and a perceived sense of blame by others is an oppressive burden, and the impact can result in defensive practices (Just, Palmier-Claus and Tai, 2021).

Being confident in building a therapeutic relationship and the associated interpersonal skills, can create more awareness and boost confidence in working with self-harm and suicide. By being present in the moment with a person who is experiencing thoughts of suicide, mental health nurses can be in a better position to offer honest engagement with the risk experienced by that person (Awenat *et al*, 2017). By maintaining focus on the person and imagining the experience from their perspective, the mental health nurse can take 'considered' risks in partnership with the patient (Zalsman *et al*, 2016).

1.5 Forum Theatre in the Education of Mental Health Nurses

1.5.1 Role of mental health nurse education

The role of mental health nurse education is to develop nurses who can deploy a range of skills that aim to promote and support a person's recovery journey through mental ill health, helping them to live independent and fulfilling lives (Evans, Nizette and O'Brian, 2019). The role requires an ability to build effective relationships with people who use mental health services, and with their relatives and carers (Gerace, 2020). Success comes from being able to establish trusting relationships quickly and to help individuals understand their situation and reach the best possible outcomes (Gunasekara *et al*, 2014). Communication and interpersonal skills are crucial, as well as strong judgement, ability to teach, advise and manage people (Evans, Nizette and O'Brian, 2019).

Evidence from research and effective practice consistently demonstrates that key interpersonal qualities and communication skills are positively associated with active engagement in care, treatment, and positive patient outcomes (Browne, Cashin and Graham, 2012; McAndrew *et al*, 2014; Stickely and Freshwater, 2006). Communication influences how relationships with others develop and work, and is key to the provision of person-centred care tailored to meet the needs of the individual (Martin and Chanda, 2016). To provide effective care, it is important for mental health nurses to continually develop awareness of how they communicate and the influence of this on the therapeutic relationship with patients (MacLean *et al*, 2017). It is a complex dynamic process that frequently happens outside of a person's awareness (Barker, 2017). Mental health nurses need to develop this process as fully as possible to

promote a partnership relationship that engages and sustains a patient with their care and treatment.

As a nurse educator it is important to develop teaching strategies that draw upon a sound theoretical basis to meet the learning needs of students. Traditional didactic or simulated learning strategies can highlight the 'do's' and 'don'ts' of communicating with others, but it can be argued that they do not offer as much opportunity for individuals to explore in depth the attitudes, beliefs and behaviours that can influence their own interactions (Aubrey and Riley, 2018; Middlewick, Kettle and Wilson, 2012).

1.5.2 Drama in nurse education

In recent years there has been a trend towards the use of simulated scenarios using actors to play the role of patients in nurse education (Felton and Wright, 2017). Using trained role-players provides learners with an opportunity to experiment with different situations and approaches that require application of communication skills (Lane and Rollnick, 2007; Taylor *et al*, 2018; Wilson and Walker, 2016). Using simulation in this way can provide a low-risk environment for learning where students can make mistakes without causing emotional harm to patients (D'Ardis, 2014; Wilson, 2013). They create a vehicle to explore issues and communicate information around social and peer conventions (Davis, 2014; Glik *et al* 2002; Norris, 2016). Drama is recognised as an important approach in connecting and engaging people working with complex and sensitive issues (Daykin *et al*, 2008; Joronen, Rankin and Astedt-Kurki, 2008).

1.5.3 Forum Theatre in mental health nurse education

The Forum Theatre workshop (Appendix 1) used for this study draws on Forum Theatre (Boal, 2000) and constructivist-based learning theories; Experiential Learning (Kolb, 2014) and Transformative Learning (Mezirow, 1978). These theories emphasise the application of prior knowledge through personal experiences and assumptions of the environment, triggered responses, perspective taking and increased self-awareness through reflection. Boal, Kolb and Mezirow's theories complement each other to elicit mental health nurses own cognitive and emotional responses to problem solve challenging practice scenarios.

The aim of Forum Theatre in the context of this study was to explore real practice scenarios in a way that empowered learners to rehearse solutions and change the outcome of a consultation for the better. The scenarios were based around working with distressed patients who are experiencing a mental health crisis and are at high risk of self-harm and suicide. Forum theatre provides a very powerful tool for learning and changing behaviours, which is practiced in a relaxed and engaging way that facilitates the sharing of personal reflections and experiences (Epskamp and Epskamp, 2006). The Forum Theatre process can allow mental health nurse educators to help mental health nursing students develop those skills in realistic mental health scenarios and role model those skills as a facilitator.

This project evolved from the researcher's professional experience in the development and delivery of Forum Theatre based interventions across a range of settings to support mental health nurses and psychiatrists both in the UK and internationally. These Forum Theatre sessions focused on the communication skills required to support patients while completing clinical tasks such as mental state examination, history taking, risk assessment,

psychoeducation and more. Actors were used to play the role of patients presenting with many different mental health disorders and associated psychosocial factors. The settings were varied covering acute inpatient, community, intensive care, forensic and across the lifespan. Creating a safe space for clinicians to explore skills and attributes required for effective nursing practice such as verbal and non-verbal communication, reflection, self-efficacy, emotional resilience, attitudes, values and beliefs (Mclaughlin, Pearce and Trenoweth, 2013; Pearce and Stern, 2014).

1.5.4 Summary

This chapter introduced the key concepts that underpin, frame, and position the study of Forum Theatre in relation to mental health nursing education and practice. The researcher discussed the origins and techniques of Forum Theatre and how they align with learning theory. Contemporary issues facing mental health nurses in practice were discussed including recovery focused practice and the role of therapeutic relationship in delivering safe and effective care. The impact on practice of suicide, self-harm and blame culture were discussed. Finally, consideration was given to the role of nurse education in preparing mental health nurses for practice and an outline of how Forum Theatre may play a role.

1.6 Field Notes

(Researcher field notes, May 2018)

I am currently feeling a mixture of confusion, excitement, hope and fear. I am confident in my ability to design and deliver Forum Theatre, however, I have little belief that I will ever get to grips with a project of this magnitude. I am a bit of an active, intuitive learner by nature and have always tended to run with ideas that have felt right with the situation. The same has been the case with Forum Theatre and so I hope I am able to see this whole project through without losing interest and moving on to other projects. This may be the ultimate test of my staying power and ability to commit. I often draw comparisons to my role of the educator and that of a performer, I thrive off the energy within an active classroom and use the energy to gauge the temperature and shape the direction of a teaching session in what I think is a reciprocal way. While learning and teaching is very motivating, I recognise that a doctoral study is a very different beast, and I must find new motivations beyond external validation from a group of students. There are a lot of people behind me on this project who want it to succeed which is wonderful but at the same time this adds pressure and only time will tell whether I can live up to expectations. I have an innate tendency to assume others are correct and I am wrong which I think are routed in my working-class background and experiences at school. I think I need to be mindful of these traits as I progress through the research and challenge my default assumptions ahead of entering discussion, debate and when feeling under pressure for any reason. I must also recognise the strengths of my character - I wouldn't be involved in Forum Theatre had I not been open and flexible to new ideas, practices, and opportunities.

I thought this poem by Berholt Brecht the German theatre practitioner, playwright and poet was quite appropriate as I begin this journey:

So there you sit. And how much blood was shed
That you might sit there. Do such stories bore you?
Well, don't forget that others sat before you
who later sat on people. Keep your head!
Your science will be valueless, you'll find
And learning will be sterile, if inviting
Unless you pledge your intellect to fighting
Against all enemies of all mankind.
Never forget that men like you got hurt
That you might sit here, not the other lot.
And now don't shut your eyes, and don't desert
But learn to learn, and try to learn for what.

Berholt Brecht – To the students of the workers' and peasant's faculty

Chapter 2 Literature Review

2.1 Introduction

Chapter two provides a systematically conducted review of the literature informed by the Joanna Briggs Institute guide to systematic reviews (JBI, 2015). The chapter first sets out a rationale and identifies questions for the review. A search strategy is provided that includes the eligibility criteria and demonstrates the process for selecting articles. The results are provided with the process for quality appraisal and synthesis to demonstrate how the themes were generated. The key themes are discussed and used to generate the research aim, questions, and objectives to conclude the chapter.

Initial literature searches revealed that using 'drama' as a teaching strategy is well evidenced, as is the argument for experiential learning and the impact it can have on skill sets. The origin of Forum Theatre and its movement into the broader field of education is also well documented. However, in relation to practice, despite an emerging body of interest, the evidence for Forum Theatre as a teaching strategy within healthcare education appears limited. Initial searches highlighted anecdotal evidence that it is being used in the classroom to teach healthcare professionals and with positive effect, but that there is a lack of primary research aimed at understanding the impact of Forum Theatre in healthcare education.

With these observations in mind, it was evident that a more systematic approach to searching and reviewing the literature would be appropriate, and would provide an opportunity to develop a map and examine the available evidence on the use of Forum Theatre in healthcare education.

The process of identifying, mapping, and examining the evidence available helped reach some consensus and identify gaps for justifying the study and developing the research questions.

2.2 Objective and Questions

2.2.1 Literature review objective

The objective of the review was to examine and map the literature on the use of Forum Theatre in the education of healthcare professionals and use the results to inform the research questions for the study.

2.2.2 Literature review questions

- How is Forum Theatre being used in the education of healthcare professionals?
    - Identify the participants
    - Identify the settings
    - Identify areas of practice being addressed
- What key themes are identified in the literature on the use of Forum Theatre in the education of healthcare professionals?
- What type of study designs are used to describe the use of Forum Theatre in the education of healthcare professionals?
- What gaps in research can be identified on the use of Forum Theatre in the education of healthcare professionals?

2.3 Search Strategy

This study used Ebscohost to access a range of databases including Academic Search Elite, MEDLINE, CINAHL Complete and PsycINFO. The databases were considered suitable for this literature search as they provide access to a broad range of allied health, arts, science, educational and psychological full text journals.

In order to ensure a systematic approach to the literature review, the PICo mnemonic was applied (Table 1) to help frame the questions and inform the inclusion and exclusion variables (Coughlan *et al,* 2017). Although a range of mnemonics have been described for different types of review, the JBI suggest that the PICo mnemonic can be used to construct a clear and meaningful question for a JBI systematic review of qualitative evidence. The PICo mnemonic stands for the Population, the Phenomena of Interest, and the Context. There is no need for an outcome statement in qualitative synthesis

Table 1: PICo mnemonic

P	Population/Problem	All healthcare professionals or students (Undergraduate/post-graduate) who have participated in Forum Theatre training.
I	Interest	Literature that describes, examines or evaluates the use of Forum Theatre in the education of healthcare professionals or students.
Co	Context	This considers literature that addresses the use of Forum Theatre in the education or training of healthcare professionals or students in any educational setting.

2.3.1 Search terms and keywords

According to Gray (2017), search terms used within a literature review should be associated with the research title. The terms used for this review have been considered relevant to the topic (Table 2).

Table 2: Search terms and keywords

Search words	Field
"forum theat*" OR "theat" for development" OR "theat* of the oppressed" OR "drama" OR "role play"	Title
AND nurs* OR health* OR "education" OR "student" OR "Med*"	(No field assigned)

2.3.2 Boolean, truncation and wildcard operators

Boolean operators (e.g. “AND”, “OR”, “NOT”) were included (in block capitals) to expand and narrow the search where necessary. The use of Boolean operators allows the researcher more control over the searching process so that the search becomes more refined in its attempt to find the appropriate literature (Cronin, Coughlan and Smith, 2015; Gray, 2017). Similarly, truncation operators improve the search process by using a keyword to identify and include other variants (Aveyard, 2015). The ‘trunk’ of the keyword is followed by a (*) informing the databases to select all keywords starting with this stem (Cronin, Coughlan and Smith, 2015). It is recommended that variety of search options are performed to ensure a comprehensive search of the literature is conducted (Hart, 2018). For this literature review a university librarian was consulted to assist in refining search terms.

2.3.3 Inclusion and exclusion criteria

Inclusion and exclusion criteria have been applied to the search strategy to limit the findings and reduce the number of unsuitable studies or subsideries. The criteria were designed to align with the research questions and aims, as well as reflect the PICo (Table 3)

All international literature that is published in English was included. It was not possible within the scope of this review to offer translation of literature in any other language. Any literature published since 1970 was included as this is the date that Forum Theatre was first pioneered.

For the purpose of the literature review the source type was 'open'. It considered quantitative, qualitative studies and systematic reviews along with other sources, including peer reviewed articles, commentary papers and newspaper articles. The researcher's background knowledge of the subject, along with the results of an initial scoping review, indicates that limited primary research is available and thus restricting the search by source type would be too limiting.

This review considered literature that addresses the use of Forum Theatre in the education or training of health care professionals in any educational setting. For this literature review, it was important to define the context of education. A preliminary search of the literature revealed that Forum Theatre has been used as an education tool in health promotion, mostly attributed to its emancipatory roots. For example, sexual and reproductive health promotion, Lupus, and environmental justice, has been mostly used in Africa to teach about HIV and AIDS (Plastow, 2009; Williams *et al*, 2009). While this literature is important in building on the background knowledge base for Forum Theatre in healthcare, it was decided that health promotion provided the wrong context, and does not reflect the PICo criteria and therefore doesn't answer the literature review questions.

It was decided that this review would include 'other' sources outside of the database initial results. Furthermore, it was decided that any relevant titles found through the reference lists of full text articles from the database search would be included as this is considered best practice to ensure a systematic approach to literature review (Joanna Briggs Institute, 2015).

Table 3: Inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
Full text only Drama in title Forum Theatre in title or full text Population Health Professionals or students; Nursing Medical Dental Midwives Occupational Therapy Education Grey Literature	Pre-dating 1970 Outside healthcare field Language other than English Regarded as insufficient to be used as evidence eg. poster literature / abstract for a conference / letter. Public health / Health promotion raising awareness rather than the teaching of healthcare staff or students. Drama in the broader sense as a teaching technique (does not specify Forum Theatre in full text). University staff / trainers are the participants undertaking the training rather than health care professionals / students. Drama or theatre not in the abstract Environmental health

2.3.4 Selection for inclusion

The initial database search yielded 49 results. Initially four 'other' titles were added to the process and seven 'other' titles were added for screening level one later, following a search of the full text bibliographies. Of the 60 titles screened, fourteen were duplications and removed. Leaving forty-six that were screened against the inclusion/exclusion criteria. At this stage, twenty-six titles were excluded based on population and their focus on health promotion/public health, environmental health, and an insignificant conference abstract/letter.

Twenty-one full texts were retrieved and examined using the inclusion and exclusion criteria. Seven full articles were excluded based on; population (4), environmental health (1), Drama in the broader sense (1) and as a teaching technique, does not specify Forum Theatre and was insufficient as a conference abstract (1).

The JBI Critical Appraisal checklist (Joanna Briggs Institute, 2015) appropriate to the type of study (qualitative or text/opinion) was applied to check the quality of the articles and make any initial notes, (Appendix 2). At this stage one article was excluded as it did not meet the quality criteria due to being a copy of a newspaper clipping written by a journalist that simply reported on a Forum Theatre exercise. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram (Figure 1) charts the screening process (Moher *et al*, 2009).

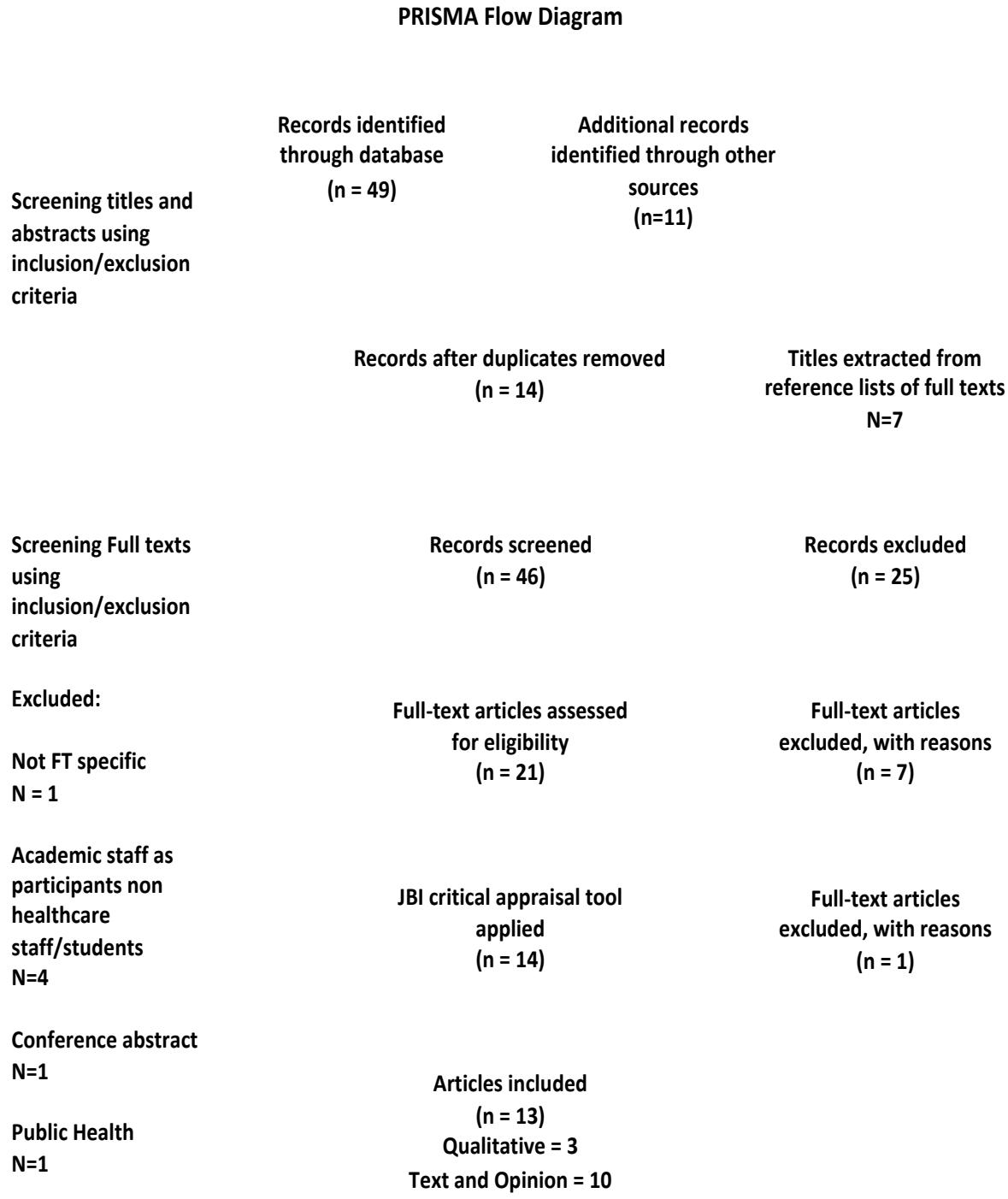

Figure 1: Prisma flow diagram

2.3.5 Data extraction and quality appraisal

The appropriate JBI data extraction tools were used to extract information from the remaining thirteen articles. The JBI data extraction tool for qualitative research (Joanna Briggs Institute, 2015) tool was used for four identified qualitative articles (Appendix 3). The tool was used to assess; the research aim, methodology, participants, data collection and analysis, ethical issues, data analysis, findings, and key points. Levels of credibility were applied, unequivocal/credible/not supported. There were no unequivocal studies because their findings were all open to challenge and couldn't be reported as beyond doubt. All studies therefore recorded as credible.

The JBI textual data extraction tool (Joanna Briggs Institute, 2015) was used for the ten studies that were considered text and opinion (Appendix 3). The tool was used to gather data on the type of text and opinion, population, healthcare setting, and key points from discussion through assessment of clarity of argument put forward by the author/s. Notes were also made of any points of interest to report. Levels of credibility were applied, unequivocal/credible/not supported. All textual articles were found to be credible as their conclusions were plausible considering the information on the subject and theoretical framework underpinning the discussions.

2.3.6 Synthesis

A three-stage method to thematic analysis developed by Thomas and Harden (2008) was used to synthesise the extracted data. Stage one and two were a process of coding text and developing descriptive themes, and stage three was generating the analytical themes. Notes were made during data extraction through reading, re-reading, and reflecting the findings of

the qualitative studies and key points/conclusions from textual articles. In the first stage, manual line-by-line colour coding was used to highlight text/points that might address the literature review questions. The second stage involved organizing those codes into groups and abstracting the key components into descriptive themes.

In the final stage, the descriptive themes were used to interpret a new thematic synthesis. This was completed through a process of reflecting upon and analysing the similarities and differences of the descriptive themes. Patterns were identified that offered deeper meanings and revealed fresh insights. Three themes emerged through the synthesis process, creating a greater level of abstraction.

2.3.7 Results

Results indicated a lack of literature specifically on the use of Forum Theatre in the development of mental health nursing skills were limited to ten opinion pieces and four qualitative studies. Three broad descriptive themes emerged in the analysis: Role modelling positive power relationships; The learning process; Developing communication skills. The included articles and their contribution to the results are presented in a final data extraction table (Appendix 4) with description of the included qualitative and text/opinion articles, their characteristics and contribution to the three themes.

2.4 Theme 1: Role Modelling Positive Power Relationships

This theme emerged through several authors observations and reflections on how Forum Theatre addressed oppression from different angles from healthcare worker perspective.

Considering Forum Theatre's creation as an approach to emancipate communities from social oppression then this was perhaps from an alternative angle. The findings and key points that went to shape this theme are presented and discussed in this section.

2.4.1 The relationship between learner and teacher

The relationship between student and teacher was addressed in several text/opinion articles (Kemp, 2009; Love, 2012; McClimens and Scott, 2007; Wilson, 2013). The relationship between facilitator and student in a Forum Theatre session was highlighted as an opportunity to model positive power relationships, for example, McClimens and Scott, (2007) argue that the facilitator can model inclusive communication and foster openness, thus moving away from hierarchal power relationships. Failing to address this may result in people feeling powerless against those in a position of power. Frustrations can lead to people acting out towards one another through a phenomenon known as horizontal violence (Kemp, 2009). Love, (2012) suggests that the facilitators of Forum Theatre should themselves receive supervision for this style of training, and further suggest researchers consider the training and support needs of the facilitator in more depth.

Examples of this concept are visible in teams who have suffered hierarchal oppression alongside resource issues (Love, 2014). Being ill equipped with the interpersonal skills to support people in distress can further compound powerlessness for healthcare workers. Wilson, (2013) draws on this concept and highlights how the person-centred approach within Forum Theatre can aid development of resilience, professional confidence, and skill level which can therefore help reduce work stress related burnout of individuals and teams in line with its emancipatory roots.

Good role modelling also reflects best practice in terms of the power position of nurses aligning with the concept of person-centred care where patients, families and carers actively participate in their own treatment in close cooperation with health professionals (D'Ardis, 2014). A further example of this is provided by Kemp (2009). Kemp discusses the expertise of the facilitator and the actors in portraying stereotypes and how to improve oppressive dynamics in midwifery such as over-looking the role of the birthing partner.

2.4.2 The role of institutional oppression on staff wellbeing

The socio-political context of healthcare systems needed to be considered as a key factor in the analysis of Forum Theatre as an educational tool in several text/opinion articles (Kemp, 2009; Love, 2012; McClimens and Scott, 2007). In recent years there have been unparalleled pressures on the UK healthcare system (Jarden *et al*, 2019). Several papers comment on the relevance of the anti-oppressive benefits of Forum Theatre in healthcare education during a period of increased financial pressure due to an increasing population and evermore diverse health needs (Kemp, 2009; Middlewick, Kettle and Wilson, 2012; Wilson, 2013).

Roberston *et al*, (2017) discussed the growing gap between demand for services and available resources means that staff are acting as shock absorbers, working longer hours and more intensely to protect patient care. Robertson *et al* (2017) found that this led to higher levels of stress and, in some cases, increasing absence due to sickness. There is a well-established link between staff wellbeing and the quality of patient care (Hall *et al*, 2016; Ham, 2014).

2.4.3 Challenging oppressive practice

Some of the text/opinion literature identified how Forum Theatre can be used to address oppressive practice in healthcare through challenging oppressive practices and stigma.

D'Ardis (2014), envisaged a much greater role for mental health nurses in tackling health inequalities, particularly in communities with the worst health outcomes. This might be in terms of a whole community or individuals within it, for example by tackling social stigma.

Wilson (2013), advocates for patient involvement in health and social care education to address stigma, and in his evaluative article he uses the narrative of people who have been supported by mental health services. Seven patient volunteers joined together with two members of lecturing staff to be involved in the production process of Forum Theatre to enhance realism and reduce risk of stereotyping and stigmatization by actors though accurate portrayal.

McClimens and Scott, (2007) echoed Wilson's conclusions in a small training pilot for learning disability nursing students and concluded that Forum Theatre can be a platform to both understand and challenge, where necessary, cultural issues of stereotyping as well as personal values and beliefs that can lead to oppressive practice.

2.5 Theme 2: The Learning Process

The learning process was a very clear theme that developed through analysis of the literature and its relation to learning theory. It provided some insight and consensus into the alignment of Forum Theatre with established learning theories and comparisons to other approaches to learning and teaching.

2.5.1 Experiential learning

The nature of Forum Theatre allows the student to bring knowledge to influence the narrative of an interaction and find solutions to problems in the interaction. McClimens and Scott, (2007) in a commentary on a pilot training programme for Learning Disability nurses that used Forum Theatre attributed the success of the Forum Theatre model to the involvement of students in directing their own education. This problem-based approach to learning through experience aligns with constructivist-based learning theories from the likes of Dewey, (1938); Kolb, (2014); Mezirow, (1997); Schmidt, (1983) and constructivist social learning theory pioneered by psychologists Bandura, (1976); Vygotsky, (1978).

The constructivist theories were a common thread within text/opinion articles, (D'Ardis, 2014; McClimens and Scott, 2007; Middlewick, Kettle and Wilson, 2012; Wasyklo and Stickley, 2003; Wilson 2013). These articles highlight how an emphasis on application of prior knowledge, through personal experiences and hypotheses of the environment can trigger responses, increase self-awareness and the skills of reflecting 'in' action. The reflective process that is inherent in Forum Theatre, can lead to a deeper level of learning through active participation was highlighted in findings from two of the qualitative studies (Kruger *et al,* 2005; Nordstrom, Fjellman-Wiklund and Grysell, 2011).

These theories create the instructional design of the learning process through reflective observation, recognition and recall of familiar skills, reduced boundaries, and freedom to problem-solve and rehearse potential real-life experiences to enhance the learning experience (Love, 2012). The opportunity in Forum Theatre to rehearse for the future (D'ardis, 2014; Love, 2012), reflect and modify approach and witness immediate results, encourages active

reflection and sharing of ideas and experiences (Tuxbury, McCauley and Lement, 2012). Furthermore, in their qualitative study Jacob *et al* (2019) found that these components combined to create a high level of learner engagement.

The benefits of this approach to learning in the Forum Theatre process were acknowledged in the findings of Himida *et al*, (2019). Their qualitative study explored the usefulness of Forum Theatre in teaching clinical undergraduate dental students how to break bad news to their patients. Key findings through their framework analysis were how the problem-based approach and the ability to bring participants own knowledge and share knowledge, provoked openness to learn and contributed an increased sense of confidence in breaking bad news.

Nordstrom, Fjellman-Wiklund and Grysell, (2011); Tuxbury, McCauley and Lement, (2012) highlight how Forum Theatre embodies the constructivist approach to learning using techniques such as; problem solving, reflecting, discussing, rehearsing and developing communication skills and improving confidence. Forum Theatre stimulated internal processes, challenging internal vulnerabilities to bring about positive change.

In their qualitative study Nordstrom, Fjellman-Wiklund and Grysell, (2011) explored Forum Theatre as a pedagogical tool for practising death notification, and highlighted how for a change to happen in participants, there needs to be an openness to address vulnerability. Through facing anxiety and being brave, students discovered they had the capacity to manage in situations they had felt unable to manage before. Nordstrom, Fjellman-Wiklund and Grysell, (2011), analysed semi-structured interviews of 4th year medical students regarding death notification.

Their study used Bloom's taxonomy to analyse the interview data and found that Forum Theatre had allowed students to display a high degree of comprehension and application of knowledge in the cognitive domain, experienced tension, excitement, and adrenaline while some found a sense of nervousness and insecurity in the effective domain. With regards to the psychomotor domain an increased awareness of their own body language and speech was noted.

2.5.2 Social learning in small groups

For the opportunity to fully immerse in a Forum Theatre session beyond observation and the SpectActor role the literature highlighted the need for small group sizes. It was argued that smaller group sizes create a less pressured environment for people to feel able to perform in front of others (Jacob *et al*, 2019). However, individuals in groups need to be taken out of their comfort zone and feel some level of vulnerability (Wasyklo and Stickley, 2003). By working with groups with whom learners are less familiar there is an opportunity to witness different perspectives and be challenged enough to allow for transformative learning (Love, 2012).

In a qualitative evaluation of student feedback on using Forum Theatre in an undergraduate pharmacy curriculum, Jacob *et al* (2019) found that small group size can enable an environment that provides space and time for personal feedback, discussion and reflection when addressing communication skills. A qualitative study conducted by Himida *et al* (2019) also noted that group size impacted on student experiences and smaller groups prevented more outspoken students to dominate group discussion.

The literature also noted that Forum Theatre on a larger scale with a bigger audience can remain a powerful tool. They discussed how larger groups may be less threatening to people who are

anxious about speaking and prefer to be a more passive observer (Nordstrom, Fjellman-Wiklund and Grysell, 2011). Being part of a bigger group means participants may still benefit from witnessing the play and how different approaches can bring about change in a difficult situation (Love, 2012).

A qualitative post simulation evaluation of a small pilot study that used Forum Theatre for End-of-Life training found that 62% of students agreed with the statement 'I learned as much from observing my peers as I would if I were actively involved in caring for the simulated patient' – although only 2 students took part and 43 observed (Tuxbury, McCauley and Lement, 2012). However, in terms of healthcare education smaller group sizes are likely to be more transformational in developing skills required for effective care (Himida *et al*, 2019).

2.5.3 Comparison to other teaching strategies

A key theme throughout the literature was a theoretical comparison to other teaching strategies such as didactic (Himida *et al*, 2019; Jacob *et al*, 2019; Wilson, 2013), which it is argued does not offer the opportunity to narrow the theory practice gap and does not allow for deeper level learning over surface level. It argued that didactic teaching of healthcare skills is less engaging and therefore students are less motivated to learn (McClimens and Scott, 2007; Wasyklo and Stickley, 2003). Further comparisons were explored with role-play and limitation identified through non-actors i.e., students/colleagues or lecturer's playing the role of patients which loses a key component of realism and therefore serious engagement (Middlewick, Kettle and Wilson, 2012).

Further comparisons were drawn in the literature between various types of interactive theatre techniques, for example, creating a piece of drama, sharing it and theorizing on what has taken

place in the narrative (Love, 2012). Another comparison was drawing from another Theatre of the Oppressed technique developed by Boal (1974). The use of tableaux whereby the audience participate by creating a frozen image of an oppressive situation and then discuss what issues are arising from the image (Kemp, 2009). It was recognized that Forum Theatre offers a more immersive experience thus having further potential for change (Kemp, 2009).

2.6 Theme 3: Developing Communication Skills

The developing communication skills theme ran throughout most of the literature and provided more insight into how Forum Theatre creates an environment for developing communication skills through emotional safety and use of scenarios that are realistic, promoting more natural engagement. The literature suggested that Forum Theatre may be helpful for developing interpersonal skills that aid rapport building and engagement with patients.

2.6.1 Emotional safety

Wasyklo and Stickley (2003), in their text and opinion article explored theatre and pedagogy, using drama in mental health education, and argued that it is natural and right for mental health nurses to feel vulnerable, and express their feelings to their peers to develop emotional intelligence. They suggest that drama is an excellent medium for this process and offers a safe place to practice these skills. They highlight the need for facilitators to be aware of their responsibility for keeping the group feeling safe but at the same time to seize the moment to influence an interdependence between emotional intelligence and professional education – therefore a high level of self-awareness and facilitation skills are needed.

Goldratt and Cox, (2016) suggested through their theory of constraints that the creation of environments of high psychological safety can help people move outside or expand their comfort zones while maintaining open minds and actions. This process they suggest allows individuals to reach the ideal learning zone (Vygotsky, 1978). The nature of the learning environment in practice and complexity of nursing interventions means it can be challenging for mental health nursing students to learn safely without the assistance of an expert. Teaching in the zone of proximal development aims at positioning learners in the zone where they can develop safely with assistance from experts (Kanter *et al*, 2020).

2.6.2 Developing empathy

Wasylko *et al*, (2003) discuss how empathy can be developed through students playing the role of the patient in a Forum Theatre exercise. They suggested this can aid identification with the feeling of literally being put in the patient's shoes. However, they also found that while this was a worthwhile exercise, a peer playing the role of the patient reduces an element of realism from the interaction that would be offered using an actor.

2.6.3 Creating realistic scenarios for interaction

The realism and relevance to practice of the Forum Theatre experience was consistently reported as important in the contribution to developing communication skills. The interpretations of script, quality of acting as well as the choice of actors to ensure accurate representation, was highlighted throughout as a key factor for engagement in learning and positive outcomes for students (Himida *et al*, 2019; McClimens and Scott, 2007; Nordstrom, Fjellman-Wiklund and Grysell, 2011; Tuxbury, McCauley and Lement, 2012;). To support this, Kruger *et al* (2005) concluded in their qualitative study that a factor in poorer outcomes for students was linked to a stereotyped script where the narrative was lost as the actors

'overacted'. Inaccurately portrayed scenarios could mean that communication between actor and learner is less natural and thus reduces the value for the group, (Middlewick, Kettle and Wilson, 2012).

2.6.4 Clinical knowledge of facilitator

It was noted that in some studies the facilitator did not have knowledge of the field (Kruger *et al*, 2005). Other studies highlighted positive response to Forum Theatre methods where the facilitator did have clinical knowledge of the field (Wasylko and Stickey, 2003). There is a strong argument that in health education whereby interventions must be ethical and rooted in evidence-based practice, it is crucial that a facilitator has the expertise in the field to be aware of the nuances of mental health practice.

While mental health nurses must engage with the human condition it is vital that they work as autonomous practitioners and take ownership of their profession. Brett-MacLean, Yiu and Farooq, (2012) suggest in their reflective commentary that Forum Theatre can be used to address and enhance a practitioner's sense of professionalism. Mental health nurses need to be clear about interventions and approaches that have an evidence base in the context of working with complex mental health issues and the unique skills sets required to effectively interact and help (Wilson, 2013).

2.6.5 Interpersonal skills for use in mental health practice

While the literature addressed managing interpersonal skills in certain scenarios, for example, an angry patient in a dentist chair, there is a need for research to go much deeper into exploring Forum Theatre in mental health due to the complexity and nuanced nature of interacting in mental health nursing. The evidence that looks at other health care professions is helpful but

limited when applied to mental health and there is little evidence to date which is largely limited to peer reviewed opinion pieces. Key authors exploring the use of Forum Theatre in mental health, D'Ardis, (2014); Middlewick, Kettle and Wilson, (2012); Wilson, (2013); have identified need for mental health specific research identifying a gap in the literature which this study has aimed to address.

It is widely known that people with mental health issues experience high levels of stigmatization (Clement *et al*, 2015; Norman and Ryrie, 2018; Wilson, 2013). The literature identified how Forum Theatre can address oppression that can occur in interpersonal dynamics and in turn can challenge oppressive cultures (Kemp, 2009; Wilson, 2013). By providing an opportunity for students to develop empowering communication skills, Forum Theatre may improve navigation through complex relational dynamics that are common when working with mental health.

Forum Theatre can help students gain insights into understanding perceptions; intentions and the nuances within interpersonal relationships, between nurse and patient as well as inter-professionally (Middlewick, Kettle and Wilson, 2012; Wasyiko and Stickley, 2003). Although there is no research that has directly explored this, Kemp, (2009) and Love (2012) note the use of Forum Theatre for individually tailored learning environments as an opportunity to address a commonality of social issues. They also suggest it can be tailored to explore what is relevant to an individual's reality as part of that system and that Forum Theatre may help address individual need. However, improved confidence was attributed to getting the opportunity to actively participate and learn from other perspectives (Kemp, 2009; Wasyklo and Stickley, 2003; Wilson, 2013).

The balance between a unique individual reality and a shared socially constructed reality is a concept that is apparent in the literature. There is a need to explore and work with an individual's perceptions but at the same time, a need to work towards social harmony, and common consensus. For example, when working with those living in poverty with mental health needs, we must accept a certain degree of commonality in such groups, but we must also recognise how people experience those societal factors will differ between individuals (Jacob *et al*, 2019; Kemp, 2009; McClimens and Scott, 2007; Nordstrom, Fjellman-Wiklund and Grysell, 2011; Tuxbury, McCauley and Lement, 2012).

2.7 Discussion

The literature has described the learning process experienced by participants who have taken part in different forms of Forum Theatre in various healthcare education settings in several countries. The literature indicated how the combination of the facilitator role, safe space, personal relevance, participant engagement, problem-based learning, transfer of prior knowledge and reflective practice are important components of Forum Theatre.

An emerging body of qualitative research, albeit limited at this stage, describes a consensus of positive outcomes for students that has an empowering impact both on an interpersonal level through a development of communication skills and links this to a potential for cultural change by addressing issues related to stigma and horizontal violence. The findings are rich as they are rooted in student feedback and the main body of evidence was offered through qualitative research.

The qualitative research tends to explore student's experiences through, observation, feedback interviews and questionnaires. Some literature has highlighted future research methods to expand the evidence base whereby subjective experiences of Forum Theatre inform a quantitative study to measure impact of Forum Theatre (D'Ardis, 2014; Kemp, 2009; Love, 2012).

The literature indicates that for positive outcomes, session organisation needs to be given careful consideration. Group size and the potential need for 'mop ups' have been highlighted as factors to consider. Students also attribute the success of Forum Theatre to a safe environment that challenges, offers immediate feedback and allows for a deep level of reflection that other forms of teaching methods such as role play may not offer them.

Comparisons are drawn through theory to other forms of learning styles, and although there is currently limited qualitative evidence to support this, the quantitative 'impact' of Forum Theatre has not itself been thoroughly explored, there is a consensus in the literature to argue that Forum Theatre is more useful in teaching certain skills than traditional simulated learning or didactic methods, (Middlewick, Kettle and Wilson, 2012). This reinforces the need for research that explores experience and impact on specific areas of skill development, such as the research in this thesis.

The facilitator (or Joker) role is acknowledged to being key to achieving positive outcomes in Forum Theatre. The consensus in the literature is that the facilitator needs to be aware of the students / audiences emotional safety as well as optimize on the potential for individual change (Kemp, 2009; Love; 2012). The literature implies that where internal change has taken place,

students feel more confident in their role, more empathic and that they will in turn be providing better care (Jacob *et al*, 2019; McClimens and Scott, 2007; Wasyiko and Stickely, 2003).

Whilst not dismissing the potential for developing communication skills in areas such as medicine and dentistry. The researcher argues that mental health nurses need more than ever to be developing specialist communication skills that pick up on the nuances and complexities in dealing with patients with mental disorder as well as develop ways to protect themselves against burn out and oppressive practices. This valuable point highlights the theory to practice gap in the current knowledge that contributed to the research questions in this thesis.

2.8 Answering the Literature Review Questions

How is Forum Theatre being used in healthcare education?

Forum Theatre is being used in undergraduate and post graduate healthcare education. It is used as a teaching technique in nursing (general and learning disability), midwifery, occupational therapy, medicine, dentistry, and in professional development within acute specialist healthcare teams in the UK, USA, and Canada. Forum Theatre techniques are being used to address communication skills, issues of empowerment and social change / ethics.

What key themes are identified in the literature on the use of education of healthcare professionals?

Forum Theatre is being reported as an effective teaching strategy. The technique can address issues of power, improve communications skills, and better equip students to deal with complex / challenging situations. It is widely recognised that there is a lack of primary evidence

in this field to examine the impact and usefulness of the teaching strategy, hence the need for the current research.

What type of study designs are used to describe the use of Forum Theatre in the education of healthcare professionals?

Published and peer reviewed literature is available on the use of Forum Theatre. The main body of work is text and opinion-based, drawing on professional and academic experience with the use of student feedback to inform the piece. Primary qualitative research carried out to evaluate the impact of the Forum Theatre technique is action research in methodology, and draws on interview, observation, and formal feedback as a method.

What gaps in research can be identified on the use of Forum Theatre in the education of healthcare professionals?

The literature is considered limited in number and primary research is represented in a small minority of the available research. It is widely recognised by authors working within the academic field, that more primary research to evaluate the impact of Forum Theatre on mental health nursing skill set and practice is needed (D'Ardis, 2014; Middlewick, Kettle and Wilson, 2012; Wasyiko and Stickely, 2003; Wilson, 2013).

2.9 Generating the Study Aim, Objectives and Questions

The results of the literature review reflect the researcher's preliminary thoughts and observations about the limited availability of literature on the topic, and that the literature is

mainly anecdotal in style. A number of these authors highlighted the need for future studies that explored the experience and impact of Forum Theatre across their respective subject areas. No primary research has yet explored the individual experience of Forum Theatre with mental health nurses, and it is extremely limited across other healthcare professions. The results justified the need for the current doctoral research study and underpinned the development of the aim, objectives, and questions for the study.

2.9.1 Research aim, objectives and questions

Research Aim:

- To understand the effectiveness of Forum Theatre techniques on mental health nursing skills.

Research Objectives:

- To explore the individual experience of mental health nurses who undertake training that employs Forum Theatre techniques
- To analyse the experience in relation to specific skill sets
- To examine the impact of the application of skills acquired during a simulated practice scenario

Research Questions:

- How is Forum Theatre subjectively experienced?
- What specific skill sets are addressed by Forum Theatre techniques?
- How do individuals feel that these skills impact their practice during a simulated scenario?
- What conclusions can be drawn from the analysis about the application of Forum Theatre techniques?

2.10 Summary

This literature review revealed that there is an emerging body of work that aims to explore and evaluate the use of Forum Theatre as an education tool in healthcare education. The review also identified significant gaps in research including some specific to mental health. The literature has provided a strong consensus through theoretical exploration in text/opinion articles and four qualitative research studies on how Forum Theatre can play a role in healthcare education. Drawing comparisons to other fields such as medical/dental students was a helpful approach to understanding and considering what the outcomes might be in mental health settings, for example, addressing communication skills during difficult conversations.

The review allowed generation of the research aim, objectives and questions, and indicated the need for further research. The review has given some initial insights on how Forum Theatre is experienced by healthcare professionals and has strengthened the theoretical framework for the study, providing justification for the need of a mixed methods methodology to close the gap in the literature revealed.

2.11 Field Notes

(Researcher field notes, August 2018)

Many questions and internal debate! I have become very mindful as I have become more immersed in the philosophy that drove Boal's approach that I may be breaking the rules in how I have delivered Forum Theatre over the years – eek! Is that even allowed? Rules are there to be broken, right?! I am using the techniques but perhaps for slightly different purposes. Boal always portrayed the protagonist as the powerful oppressor figure. He denied that people have character traits that are simply their own, and instead, characters represent socially constructed roles. I am left in a bit of a conundrum as I believe I have used Forum Theatre from a slightly different perspective by challenging both subjective individual experience and wider systems influence.

For me, to suggest that patients (protagonist) represent the oppressor in a Forum Theatre session is unethical and very misleading. This has never been my approach to Forum. Users of mental health services are likely victims of societal oppression as much or more than the mental health nurse in the SpectActor role. To generalise the patient symbolically would play to stigmatizing stereotypes and undermine the individual patient experience of mental illness. I also think that while a mental health nurse is expected to be an advocate operating in the best interest of the patient, they can also be unwittingly guilty of oppression within an interaction. This oppression could be shaped and influenced by a nurse's personality traits and previous experiences as much as the organisational structures they work in, e.g., the NHS. Limited resources and pressure staff are under may shape and influence decisions that result in the oppression of the patient.

I don't believe there is a simple linear distinction between the powerful and the oppressed. The context and goal are more nuanced. My approach to using Forum Theatre with mental health nurses is to develop interpersonal communication skills delivered through a person-centred approach to gain an understanding of the individual experience and understanding of biopsychosocial factors that are causing distress. Equally, mental health nursing students need to understand psychosocial factors contributing to how they interact and how these may be impacting that interaction. Therefore, I believe that the practical use of Forum Theatre with mental health nurses could enable the group to support change in very personal individualist ways, and recognise social impact rather than a societal shift in the way Boal would have originally intended. I don't think anything needs to change off the back of this, and it has helped me solidify my decisions about methodology.

Chapter 3 Methodology

3.1 Introduction

This chapter begins by providing detailed discussion of the ontological and epistemological assumptions that underpin the study and justification for a mixed methods approach to answering the research questions. The chapter then provides details of the research design and procedures, including sample and recruitment, data collection, data analysis, validity, trustworthiness, and ethical considerations.

3.2 Philosophical underpinnings of the Study

3.2.1 Ontological and epistemological assumptions

Understanding philosophical and worldview perspectives on research, and placing a piece of research within that framework, is key to answering methodological questioning which in turn informs the choice of research design and methods for a study (Creswell and Creswell, 2020). A sound knowledge base of the philosophical framework of research assisted the researcher in justifying decisions and ensuring their research design was rigorous (Bell and Waters, 2018). Furthermore, it develops critical thinking, and can lead to consideration of future research from alternate world views and how this could deepen the understanding of the chosen topic (Fetters, 2019).

A philosophical world view is a ‘set of beliefs that guide action’ (Guba, 1990, p.17) or ‘a way of breaking down the complexities of the real world’ (Patton, 1990, p.36). These beliefs have

also been referred to as ‘paradigms’ and a paradigm can be broken down into three lines of inquiry; ontology, epistemology and methodology (Guba and Lincoln, 2000).

Ontological considerations relate to the nature of reality and its characteristics. The researcher must reflect on whether for them reality is viewed as external to the individual or a product of the individual’s consciousness (Ghiara, 2020). Epistemological considerations deal with what counts as knowledge, and the nature and forms of knowledge. Moreover, epistemology explains why our minds relate to reality and how these relationships are either valid or invalid. It is needed to distinguish between the truth and falsehood as we obtain knowledge from the world around us (Cohen, Manion and Morrison, 2011). Methodological considerations deal with the way knowledge is obtained in a systematic way (Silverman, 2013). Ontological and epistemological assumptions underpin the philosophical stance taken to a research project informing the methodological approach (Coates, 2021).

It is important to recognise that addressing ontological and epistemological assumptions that shape a researchers world view can be complex. Navigating through the philosophical debate can cause bewilderment and potential for much critical scrutiny as it is often debated, understood, and communicated in multiple correct ways (Bergman, 2015). Furthermore, literature on this subject reveals multiple ways to approach the classification of differing world views, how they often overlap, and how they are difficult to compartmentalize (Crotty, 1998). Guba and Lincoln suggest that in healthcare research a paradigm could be simply seen as; ‘the most informed and sophisticated view that its proponents have been able to devise in response to the ontological, epistemological, and methodological questions’ (Guba and Lincoln, 2005 p.35).

Four world views that often underpin quantitative, qualitative and mixed methods research studies include; post-positivism, social constructivism, critical theory, and pragmatism (Creswell, 2008; Tashakkori, Johnson and Teddlie, 2020; Bergman, 2015). These world views were considered in relation to informing the methodological approach to the study.

3.2.2 Post positivism

Post-positivism is rooted in the ontological belief that there is an objective reality that exists in the world (Williams, 2016). For post-positivists, knowledge is conjectural, and although a reality exists, researchers will never be able to know absolute truth as a researcher can never be wholly objective from the research, they can only make their best attempt at obtaining it (Philips and Bubuleus, 2000). Therefore, post-positivists would never attempt to prove a hypothesis, but would indicate a failure to reject the hypothesis. Quantitative research tends to be rooted in the post-positivist world view (Bell and Waters, 2018). Research through this lens is concerned with deductive forms of enquiry where researchers focus on cause and effect thinking and the testing of theories that are continually refined (Ghiara, 2020).

3.2.3 Social constructivism

Social constructivism can be seen as a direct rejection of the ontological notion of an objective reality from post-positivistic thinking (McCarten and Robson, 2015). For social constructivists reality is subjective and can never be seeking of an objective truth about the world. In social constructivism, meaning can only ever be found in the experiences of the individual and there are as many realities as there are individuals (Crotty, 1998). The subjective meaning for the individual is formed through interaction with others and through historical and cultural norms that operate in people's lives (Guba and Lincoln, 1985).

The epistemological assumption behind social constructionism is rooted in the idea that the researchers own background shape their interpretation of the researched (Creswell and Plano-Clark, 2017). The researcher then positions their self in the study to acknowledge how their interpretation flows from their personal, cultural, and historical experiences (Creswell, Clark and Garrett, 2008). Research adopting a social constructivist perspective is qualitative as the researcher seeks complete clarity of the individuals lived experience to be able to attempt to construct meaning or theory (Clark and Ivankova, 2015). Grounded Theory, Phenomenology and Ethnography are a few key examples of methodologies that represent the social constructivist worldview.

3.2.4 Critical theory

The world view of a critical theorist poses a challenge to the assumptions of post-positivist and social constructivist thinkers (Guba and Lincoln, 2005). While the ontological approach of this world view is similar to post-positivism through its objective view of reality, it differs in that it suggests that this reality has been influenced by a variety of social, political and cultural factors, and this construction marginalises certain groups in society (Creswell, 2014). Critical theorists would suggest that through the passages of time these social, political and cultural influences become accepted as reality, while not necessarily representing a true reality (Curry and Nunez-Smith, 2014). The epistemological assumption in critical theory is a recognition that the researcher plays a fundamental role in influencing the researched in a subjective way (Coates, 2021).

The researcher adopting this world view would aim to address a form of oppression and the methodology would be qualitative, aimed at transforming the subject area through emancipation. Critical theorists focus on political and theoretical frameworks for research such

as disability theory and feminism (Tashakkori, Johnson and Teddlie, 2020). Critical Theory Research will often contain an action agenda for reform that may change the lives of the participants, the institutions in which the participants work or live, or the researcher's life (Creswell, Clark and Garrett, 2008).

3.2.5 Pragmatism

Pragmatism was identified as the most appropriate stance for this study. Pragmatism is a rejection of the traditional ontological discourse between post-positivism and social constructivism in the search for reality (Creswell and Creswell, 2020). As a theory for mixed methods research, pragmatism recognises the concept of a reality independent of our minds, and argue that this reality can never be determined, it is never context free and is ever changing (Williams, 2016). Instead of searching for an objective 'truth', pragmatists aim to grasp an understanding of the 'truths' that people live by in their everyday life, how they shape their lives according to these truths, and how they seek a shared consensus from their individual experiences (Creamer, 2017).

A pragmatist would focus on research as a practical response to a problem (Dewey, 1916). Therefore, the methodological stance would be that research is a problem solving task that can help complete a puzzle rather than act as a platform to respond to ontological and epistemological questioning. Pragmatic thinking therefore tends to draw upon a mixed method approach to research, underpinned by the ontological assumption that reality is what is useful, is practical, and works (Creswell and Plano-Clark, 2017). The epistemological assumption that reality is known through making use of methods available that reflect both objective and subjective evidence (Tashakkori, Johnson and Teddlie, 2020).

The key strength to using pragmatism to address the research questions in this study was the acknowledgment that it can overlap world views (Morgan, 2014). To illustrate this, in the case of this study, it was possible to embrace the social constructed reality in the constructivist world view as pragmatists do recognise that research occurs in social, political and historical contexts. Aspects of critical theorist ideology can also be incorporated as pragmatism does have a post-modern turn and a theoretical lens that is reflective of social justice and political aims (Creswell, Clark and Garrett, 2008). Post-positivism could be integrated with a view to understanding some level of objective truth of reality at that point in time.

Pragmatism permitted the researcher to encompass the strengths of other world views but does not offer them in isolation from one another and is not restricted by the ontological debate in doing so. Pragmatism provided a single lens that allowed for a multitude of components of alternative world views and draw on these to best answer the research questions.

3.3 Mixed Methods

Pragmatists tend to draw upon mixed methods because of the epistemological assumption that a range of deductive and inductive tools for gathering evidence can be utilised to answer questions and solve problems in understanding reality (Feilzer, 2010). A Mixed methods approach begins with the assumption that the researcher gathers evidence based on the nature of the question and theoretical positioning (Creswell and Creswell, 2020). Qualitative methods allow the researcher to identify previously unknown processes, explanations of why and how phenomena occur, and the range of their effects (Guba and Lincoln, 1994). Quantitative

methods are useful for measuring pervasiveness of known phenomena and central patterns of association, including inferences of causality (Bell and Waters, 2018).

Mixed methods can draw on the merits of both qualitative and quantitative methods and is more than simply collecting qualitative data from interviews, or collecting multiple forms of qualitative evidence (e.g., observations and interviews) or multiple types of quantitative evidence (e.g., questionnaires and tests). A mixed methods study will include the deliberate collection of both quantitative and qualitative data, combining the strengths of each to answer research questions (Bergman, 2015).

Rather than being seen as a hybrid, mixed methods is now widely accepted as a methodology within its own right (Creswell, Clark and Garrett, 2008). Furthermore, pragmatists would argue that research on any given question at any point in time falls somewhere within the inductive-deductive research cycle, and in doing so would question traditional classifications of quantitative and qualitative research projects (Creswell, 2014; Teddlie and Tashakkori, 2009). Historically there are, for example, plenty of qualitative studies that use in depth interviews which aim to reveal patterns of behaviours and social processes to then apply to a specific population. Likewise, using forms of statistical interpretation of data does not need to mean that the researcher is rejecting the idea of a subjective reality (Bergman, 2015).

The literature review (Chapter 2) identified significant gaps in primary research including that specific to mental health and offered some consensus on approaches needed in future study. A number of these authors (D'Ardis, 2014; Kemp, 2009; Love, 2012, Middlewick, Kettle and Wilson, 2012; Tuxbury, McCauley and Lement, 2012) highlighted the need for studies that undertook a deeper exploration of the experience of Forum Theatre. Impact on sample

population was also indicated as important to follow up in relation to evidencing Forum Theatre as a Pedagogy in healthcare education and skill development across respective subject areas (Brett-MacLean, Yiu and Farooq, 2012; D'Ardis, 2014; Himida *et al*, 2019; Wasyiko and Stickely, 2003).

Mixed methods that used qualitative and quantitative procedures for data collection and analysis made a lot of sense because they would provide an opportunity to explore and understand the subjective experience, identify themes, and test those themes objectively for reliability across a larger population (Fetters, 2019). Therefore, a mixed methods approach provided an opportunity for completeness (Creamer, 2017). One method could be used to inform and/or be contrasted with another, illuminating similarities or differences. This enabled the researcher to bring together a more comprehensive and credible account of the use of Forum Theatre with mental health nurses.

3.4 Research Design

Four major mixed method designs that might be considered for use in conducting mixed method research put forward in the literature were considered - Concurrent, Embedded, Explanatory and Exploratory (Bryman, 2006; Creswell and Plano-Clark, 2017; Greene, Caracelli and Graham, 1989). The designs differ in their approach in relation to the problem to be solved and so the researcher carefully deliberated on which design would be most advantageous to meet the aims and objectives of the study. As well as selecting one of the four designs, the researcher also needed to decide on the use of concurrent or sequential timing for both strands of the research. To ensure a strong mixed method design the researcher also had

to consider the level of interaction between the strands, the priority of each strand and when and how the two strands would be mixed (Creswell and Plano-Clark, 2017; Greene, 2007).

3.4.1 Concurrent designs

In a concurrent research design the qualitative and quantitative data is collected at the same time in a single phase and the results are converged (Teddlie and Tashakkori, 2006). The purpose of this design is to obtain different but complimentary data on the same topic to best understand the research topic with equal weight given to each data type (Leech and Onwuegbuzie, 2009). The intent is to bring together the differing strengths and non-overlapping weaknesses of quantitative methods with those of qualitative findings (Teddlie and Tashakkori, 2009). Its strengths are that it makes for intuitive and efficient design and lends itself to team research (Teddlie and Tashakkori, 2006).

Challenges to the concurrent design include potential consequences of having different samples and different sample sizes when it comes to converging the two data sets. (Creswell, 2014). Different sample sizes are inherent in the design because the reason for collecting quantitative and qualitative data is usually for distinctive purposes such as generalization and in-depth description. (Terrell, 2012). Furthermore, it can be very challenging to integrate the two different datasets and their results in a meaningful way (Creswell and Creswell, 2020).

The key reason a concurrent design was not considered the best approach for this study was the need for the qualitative and quantitative data to address the same concepts. For this study the first objective was to understand how Forum Theatre was experienced to be more specific about what concept/s would be examined in more depth.

3.4.2 Embedded designs

The Embedded design involves one data set providing a supportive, secondary role, in a study based primarily on the other data type (Doyle, Brady and Byrne, 2009). Embedded designs are used when there is a need to include qualitative or quantitative data to answer a research question within a study that is mainly quantitative or qualitative (Leech and Onwuegbuzie, 2009). This design is particularly useful when a researcher needs to embed a qualitative component within a primarily quantitative design, as in the case of an experimental study (Creswell and Plano-Clark, 2017).

Challenges of embedded designs can include difficulty integrating the results when the two methods are used to answer different research questions (Doyle, Brady and Byrne, 2009). However, the intent of the embedded design is not to converge two different strands of data to answer the same question (Creswell and Creswell, 2020). In an embedded design the two sets of results can remain separate in how they are reported on (Bergman, 2015).

An embedded design was not considered suitable for this study because the principal area of study would be qualitative and there a very few examples that exist in the literature (Tashakkori, Johnson and Teddlie, 2020) on embedding quantitative data within what would be traditionally qualitative designs (Creswell, 2014).

3.4.3 Explanatory sequential designs

The explanatory design uses a sequential timing over two phases (Creswell and Creswell, 2020). Explanatory will start with quantitative data collection and then use qualitative methods in the second phase to help explain what the quantitative data produced in the first phase

(Bowan *et al*, 2017). The data is analysed separately in sequential designs with one set of data informing the other set of data, unlike concurrent designs where the data is merged (Creswell, 2014; Tashakkori and Teddlie, 2010).

Benefits to the explanatory design are that it can be more straightforward to implement because the researcher conducts the two methods in separate phases and collects only one type of data at a time (Ivankova, Creswell and Stick, 2006). The explanatory design is more likely to appeal to quantitative leaning researchers because it often begins with a strong quantitative emphasis (Bowan *et al*, 2017). Challenges of an explanatory design can be the length of time it takes to conduct because each data collection phase is done separately, with analysis required before being able to conduct the second phase (Creswell and Creswell, 2020).

The explanatory sequential design was not considered the right choice for this study because the objectives were to explore subjective experiences of Forum Theatre and get a sense of the phenomena in relation to mental health nursing skills. This would then allow for more objective quantitative measurement of impact on the phenomena uncovered in the exploratory work.

3.4.4 Exploratory sequential designs

The exploratory design is like the explanatory in that it is a two-phase sequential method. However, this time the aim of the design is to use qualitative data from phase one to inform what is to be explored and the measures needed in the phase two quantitative stage as shown in Figure 2 (Creswell and Clark, 2011). This design starts with qualitative data, to explore a phenomenon, and then builds to a second, quantitative phase. Researchers using this design build on the results of the qualitative phase by selecting an instrument, identifying variables,

or stating propositions for testing based on an emergent theme from the first phase (Fetters, 2019). These developments connect the initial qualitative phase to the subsequent quantitative component of the study (Creswell and Creswell, 2020). Because the design begins qualitatively, a greater emphasis is often placed on the qualitative data (Tashakkori, Johnson and Teddlie, 2020).

Sequential designs are widely used across the fields of health and educational research (Creswell *et al*, 2011). However, there is a need to recognise that this design does not come without challenges. Like the explanatory design, a challenge can be the time it takes to implement due to the data collection phases being conducted sequentially (Morse & Neihaus, 2009).

A further challenge of the sequential design is that when proposing to an internal review board, it can prove harder to get approval. This is because until the exploratory phase data collection and analysis is complete with focus for the quantitative phase unveiled, the researcher is unable to provide precise procedures for phase 2 of the design (Tashakkori and Teddlie, 2009). This obstacle was overcome in this study by providing tentative direction as part of the project plan at the review board which they understood and found acceptable.

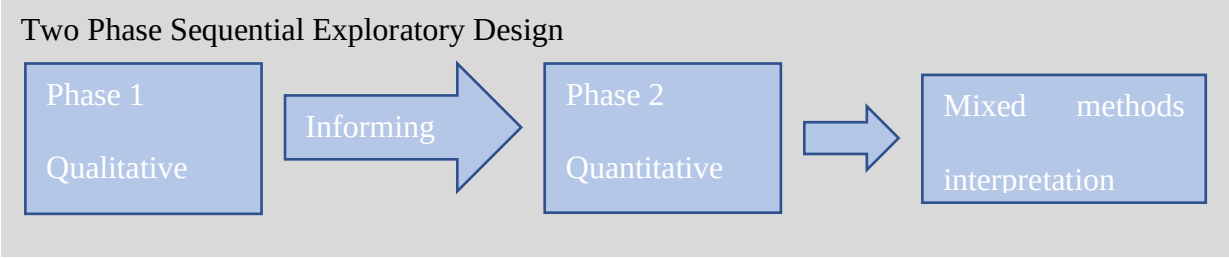

Figure 2: Two phase sequential exploratory mixed method design

The exploratory sequential design provided alignment with the objectives of this study as shown in Table 4. The researcher's intention was to explore the individual experience of mental health nurses who had undergone training that uses Forum Theatre, and to then use this qualitative data to inform a quantitative phase which was to give confirmation (or not) of the qualitative findings, and help the researcher better understand the impact of Forum Theatre techniques. By revisiting the objectives and questions for the study it was clear that they aligned coherently with the two-phase sequential exploratory design.

Table 4: Research design aligned with aim, objectives and questions

Phase	Objectives	Questions
Phase 1 Qualitative	To explore the individual experience of mental health nurses who undertake training that employs Forum Theatre techniques	How is Forum Theatre experienced subjectively?
	To analyse the experience in relation to specific skill sets	What specific skill sets are addressed by Forum Theatre techniques?
Interpretation from phase 1 to inform choice of valid and reliable measure for next phase		
Phase 2 Quantitative	To examine the impact of the application of skills acquired during a simulated practice scenario	Is there a significant difference in sense of empathy for others before and after engaging in Forum Theatre?
Interpretation (Answering the mixed methods question)	What conclusions can be drawn about the application of theatre techniques? And achieve aim: To understand the effectiveness of Forum Theatre techniques on mental health nursing students.	

3.5 Methods for Phase 1 (Qualitative)

As outlined, the sequential mixed method design adopted for this study means that the data and analysis of the quantitative and qualitative phases were to be conducted in two separate phases, starting with the qualitative. The method for each phase is provided in this section.

3.5.1 Sample

Sampling can be described as the selection of units of analysis, for example, people, groups, artefacts, or settings, in a way that fully enables the researcher to answer the questions they have set for their study (Teddlie and Tashakkori, 2009). This study used a strategy that employed purposive sampling techniques (Teddlie and Yu, 2007). A purposive sample is a sample that is selected based on characteristics of a population and the objective of the study rather than random selection (Campbell *et al*, 2020).

Purposive sampling can be very useful in situations when you need to reach a targeted sample and where sampling for proportionality is not the main concern. (Etikan, Musa and Alkassim, 2016). There are seven types of purposive samples, each appropriate to a different research objective. The main advantage of such an approach is the ability to critically think and define the parameters of the population that is intended to be studied, at an early stage (Creswell and Plano-Clark, 2017).

A purposeful sample of pre and post registration mental health nursing students taking part in a crisis intervention workshop (Appendix 1) that used Forum Theatre techniques were offered the opportunity to take part in the research. Selection for interview was based on a maximal variation strategy by recruitment of participants with a wide range of experience and

qualifications (Patton, 2005). The sample size for phase 1 was eight interviewees. Ages of participants ranged from minimum 26 years old to maximum 51 years old with an average age of 38 years old.

The sample included a mixture of participants (Table 5) including two with many years of experience and a high level of qualification, two well experienced but with less professional development throughout the course of their career, two more recently qualified, and two third year BSc nursing students. This enabled the researcher to answer the qualitative questions with some depth to create themes and be able to look at those themes in terms of applying findings to a wider population in the quantitative phase (Bryman, 2006; Creswell and Clarke, 2011).

Table 5: Phase 1 participants

Phase 1 Participants						
Participant number	Gender	Age	Experience (years)	Education level	Interview date	Interview length (mins)
P1	Male	51	20+	Diploma HE	18.04.19	47
P2	Male	28	5	BSc	10.04.19	35
P3	Male	35	3rd year BSc	Level 5/6	17.04.19	42
P4	Female	44	3	BSc	10.04.19	37
P5	Female	47	12	MSc	24.04.19	58
P6	Female	26	3rd year BSc	Level 5/6	17.04.19	43
P7	Male	39	16	MSc	24.04.19	41
P8	Female	35	10	Diploma HE	11.04.19	55

- Semi-structured interviews took place approximately three months after the Forum Theatre Workshop which took place during January 2019
- All interviews took place in a private meeting room at the Berkshire Institute for Health in Reading
- All participants had attended one four-hour Forum Theatre workshop based on mental health crisis intervention
- Participants were recruited based on maximal variation and invitation

3.5.2 Recruitment

Invitations were sent out by email to a total of sixty-one pre and post reg mental health nursing students who were all attending one of four Forum Theatre crisis intervention training workshops in January 2019. The workshops were the same in delivery with the same actors and Joker but provided over different dates to keep group sizes smaller (approximately 15 per workshop). Recruitment took place a month ahead of the workshop and expression of interest was followed up with a participant information sheet (Appendix 5) and a consent form

(Appendix 6) to be completed ahead of the workshop. Eight were selected based on their demographics as highlighted in Table 5.

3.5.3 Setting

The workshop

Participants took part in a classroom-based Forum Theatre workshop based on a crisis intervention scenario with a fictional character 'Sam Jones', who was 33 years old, lived alone, and had a long history of mental illness stemming from childhood trauma that included emotional, physical, and sexual abuse at the hands of his father (Appendix 1). The scenario was designed to focus on Sam's current challenges and risks related to self-harm and suicide. The themes for the character and his history had been developed through learning from real life cases from practice and the evidence base on factors that can increase suicide risk such as perceived burdensomeness, thwarted belongingness, and capability for suicide which can result in higher desire and intent to end life (Joiner, 2011). The scenario also included elements which could be protective factors that could be explored with the patient, such as his pet dog.

Actor Preparation and variance

A verbal and written brief was provided to the actor which outlines the role and drew from Stanislavski's (2013c) methods for developing a role including 'given information'. For example, personal background, psychiatric history, socioeconomic situation, current situation, and when and when not to share certain pieces of information during the scenario. The scenario mainly focuses on suicide risk, and engagement from the patient is based upon the quality of the communication skills of the nurse and their ability and sensitivity to exploring the challenges faced by the patient (Appendix 1).

Once a Forum Theatre scenario is underway the narrative may unravel in many ways depending on the approach taken by the SpectActors, and so variance in the scenario can be difficult to control. To completely control the scenario would be detrimental to the natural evolution of the narrative through improvisation based on the actor's embodiment of their character with the information provided in their preparation. This means that the actor preparation period is very important, as is their understanding of the concept of Forum Theatre. Therefore, it was important that the actors brief was detailed enough for them to build the character and have an indication of key areas that they should share information about if prompted in the right way by the SpectActors.

The actors were prepared for the scenario by the researcher who used his knowledge and understanding of mental health practice to ensure grounded, accurate portrayal. Furthermore, the actors used in the workshop had vast experience of working in mental health education settings and a long history of working with the researcher and university in delivering Forum Theatre workshops which provided a good level of consistency in approach.

Joker preparation

While the researcher has a lot of experience of the Joker role it was important that he maintained some distance from the participants included in the study and so a colleague from a mental health nursing background who also has a lot of experience in delivering Forum Theatre undertook the Joker role for the workshop. It was hoped that this would reduce the risk of participants feeling unable to be honest about their experience due to association in the data collection stages. The Joker's role in the context for this workshop is outlined in Appendix 1.

Format

It is important to highlight that different theatre practitioners can approach Forum Theatre in slightly different ways. Broadly speaking, the approach used for this study is based upon those provided by Boal in his Theatre of the Oppressed (Boal, 1974). The philosophical difference being the removal of the assumption that the SpectActors in the play are the oppressed. In the version used for this study it was important to recognise that the SpectActors could be the oppressor too, and as professional mental health nurses the focus was for them to identify the dynamics at play and develop skills to manage the situation in a way that helps the patient. The other difference to Boal is that the approach used in this study aimed to keep class sizes to a maximum of fifteen. This was so that there was reasonable time for SpectActors to take part in the play and reduce risk of passivity.

Drawing on Boal (1974) the workshop used for the study was four hours in length and made up of five parts including an introduction and preparation (45 minutes), a full run through of the play with the actors (15 minutes), an initial discussion (30 minutes), the forum (90 minutes), and a reflective session and debrief to finish (60 minutes), as detailed in Appendix 1. The heart of the workshop was the forum where the SpectActors become an active part of the play.

3.5.4 Qualitative data collection

There are several different data collection strategies that can be used in a qualitative design, and these were considered in light of the research questions with a view to finding the most appropriate method for this stage of the study. Common types used commonly in health research (Bergman, 2015) were considered including interviews, focus groups, and participant observation.

3.5.4.1 Focus Groups

Focus groups are used for generating information on collective views, and the meanings that lie behind those views. The main purpose of focus group research is to evoke a level of respondents' attitudes, feelings, beliefs, experiences, and reactions otherwise not available when using methods such as observation or interviewing. Focus groups are particularly useful when there are power differences between the participants and decision-makers or professionals, when the everyday use of language and culture of groups is of interest, and when wanting to explore the degree of consensus on a given topic.

Use of a focus group was given consideration for data collection for phase 1 of the study, however, the emphasis of a focus group is on shared experience. This study did aim to gain insight into any patterns across the phase 1 participants, however, the emphasis was on discovering any patterns through first analysing subjective experience and using the findings from that analysis to confirm transferability of major themes in a bigger sample.

3.5.4.2 Participant Observation

Participant Observation involves the researcher attempting to discover the practices and identify meanings that the members of the group under study develop about their experience of living (Krueger, 2014). The researcher does this by adopting the perspective of those studied (Morgan, 2015). For example, for this study the researcher would observe a Forum Theatre workshop from the SpectActor perspective. The interaction between the Actor, SpectActors and Joker would be observed. Observation can involve the combination of several methods, such as unstructured interviews, notes on observations, recordings (audio and video), and illustrative material (Cyr, 2019).

Limitations of participant observation for this study were identified as high risk of observer bias as the observer's presence might have influence on the workshop and the Joker. Video recording was considered to reduce risk of influence by presence. However, it was felt that this may still influence the workshop, potentially effecting the integrity of the workshops for the participants. Furthermore, the researcher's own unconscious bias may influence data collection due to their own long-established involvement in using Forum Theatre techniques and expectations of delivery.

3.5.4.3 Semi-structured interviews

The benefit of interviews for this study were that they would allow ample opportunity to build rapport and therefore get a more personal in-depth exploration of the experience of Forum Theatre. It was recognised that open-ended, unstructured interviews can generate a huge amount of information, but they would be too unwieldy in this context. Structured interviews were felt to be too limiting because they are very survey like in design. Furthermore, they do not allow for the order of questions to be adapted based on the interviewer perception on direction most appropriate (Robson and Mcartan, 2016).

For this study semi-structured interviews were deemed most appropriate as they would enable the interviewer to remain on topic while allowing some freedom in the sequencing of questions and the time and attention to discuss topics. Open ended questions would allow participants to express their own understanding in their own terms before moving on to a more structured range of questions that still maintain a conversational tone (Corbin and Strauss, 2015; Tashakkori and Teddlie, 2010).

The individual interviews explored the subjective experience and perspectives of the participants to extrapolate themes that informed the choice of measure for the quantitative phase. Data collected from researcher notes and the audio recordings were transcribed in the data analysis stage. A protocol template for the semi-structured interviews was developed (Appendix 7).

Interviews took place approximately three months after participants had attended the Forum Theatre workshop. Interview length varied between a minimum of 35 minutes and a maximum of 58 minutes with an average length of 43 minutes (Table 5).

3.5.5 Qualitative data analysis

There is a range of diverse and complex approaches to qualitative data analysis, and these were considered against the objectives and research questions. The rationale for the choice of Braun and Clarke's 'Six Step Method to Thematic Analysis', through a 'Qualitative Descriptive' approach and an overview of its procedures are provided in this section (Braun and Clarke, 2006).

3.5.6 Approaches to qualitative analysis

Braun and Clarke *et al* (2019) argue that thematic analysis should be seen as a foundational method for qualitative analysis. They suggest that methods to qualitative analysis can be broadly divided into two camps. The first camp belongs to those methods that are rooted in a specific theoretical or epistemological position. The second camp belongs to methods that are essentially independent of theory and epistemology (Braun and Clarke, 2019).

Within the first camp 'Interpretative Phenomenological Analysis' (Smith and Osbourne, 2003) and 'Grounded Theory' (Glaser, 1992; Glaser and Strauss, 1967; Strauss & Corbin, 1990), were considered as approaches for qualitative analysis, however, rejected based on their lack of flexibility compared to thematic analysis. Interpretative Phenomenological Analysis specifies that that the ontological and epistemological underpinnings are critical realism and contextualism (Smith, Flower and Larkin, 2009), while thematic analysis can be used widely across the epistemological and ontological spectrum. Some aspects of Interpretative Phenomenological Analysis procedures did align well with the study, such as the use of interviews, the use of a purposive, homogenous sample and type of research questions. However, they offered little more than what could be achieved through thematic analysis for the purposes of this study.

There are many iterations of 'Grounded Theory' with varied theoretical underpinnings and procedures including the very well known; 'Classic Grounded Theory' (Glaser, 1978); 'Qualitative Data Grounded theory' (Strauss and Corbin, 1990); 'Constructivist Grounded Theory' (Charmaz, 2000) and 'Feminist Grounded Theory' (Wuest, 1995). Like interpretative phenomenological analysis, whichever grounded theory approach is undertaken requires implementation of a full set of specified procedures with the aim to produce new theory grounded in data (Evans, 2013).

Forum Theatre is not a new concept, and this study is exploring its use in a particular population with view to understanding individual experience and patterned meaning across the dataset. Because this study didn't aim to explore completely new concepts and produce an explanatory theory it was decided that the flexibility of thematic analysis would be more appropriate.

Furthermore, the epistemological and ontological assumptions that underpin Grounded Theory leave it more suited to a mono method study.

3.5.7 Qualitative descriptive approach

Thematic analysis is rooted in the second camp of methods that are essentially independent of theory and epistemology and fits within the Qualitative Descriptive approach rather than the traditional methodologies already discussed. Qualitative Descriptive research studies are those that represent the characteristics of qualitative research rather than a more specific approach such as culture in ethnography, the lived experience in phenomenology, or developing theory in grounded theory (Bradshaw, Atkinson and Doody, 2017). Qualitative Descriptive research studies are those that seek to discover and understand a phenomenon, a process, or the perspectives and worldviews of the people involved (Kim, Sefcik and Bradway, 2017). As a methodology, Qualitative Descriptive research studies have gained popularity in recent years within nursing and healthcare (Doyle *et al*, 2020).

The use of a Qualitative Descriptive approach is particularly relevant where information is required directly from those experiencing the phenomenon under investigation as part of a mixed methods approach (Bradshaw, Atkinson and Doody, 2017). Thematic analysis can therefore be applied across a range of theoretical and epistemological approaches. Through its theoretical freedom, thematic analysis provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex account of data (Guest *et al*, 2011). Furthermore, adoption of thematic analysis aligns with answering the questions through the pragmatic lens of this researcher and the mixed methods approach (Glisczinski, 2018). As a doctoral researcher, many of the core skills developed in conducting thematic analysis will be transferable to other forms of analysis in the future (Guest *et al*, 2011).

3.5.8 Thematic analysis procedures

Thematic analysis was adopted as the most appropriate analytical perspective for exploring and interpreting the transcriptions of eight semi-structured interviews of mental health nurses who had taken part in the Forum Theatre workshop. Thematic analysis provided a systematic approach to identifying important and interesting patterns in the data, interpreting that data, and refining into themes that were used to address research questions (Braun *et al*, 2019). Braun and Clarkes (2006) six step method for thematic analysis was chosen to analyse the semi-structured interview data because it has been widely used and accepted as a leading framework, and offers a very clear and easy to follow process (Terry *et al*, 2017). Table 6 provides a broad overview of Braun and Clarke's six step method as used for analysis within the current study.

Table 6: Six steps of thematic analysis

	Step	Examples of procedure for each step
1	Become Familiar with data	Transcribing data; reading and re-reading; noting down initial codes.
2	Generate initial codes	Coding interesting features of the data in a systemic fashion across the data set, collating data relevant to each code.
3	Generating themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4	Review the themes	Checking if the themes work in relation to the coded extracts and the entire dataset; generate a thematic map.
5	Define themes	Ongoing analysis to refine the specifics of each theme; generation of clear names for each theme.
6	Produce the report	Final opportunity for analysis selecting appropriate extracts; discussion of the analysis and relate back to research question or literature; produce report.

In line with the pragmatic approach to the project, the aim of the thematic analysis was to answer the specific questions for the qualitative phase of the research. Therefore, a theoretical approach rather than inductive one was taken to conduct the analysis, meaning that the data was coded in relation to relevancy to the research questions. An open coding technique was employed so codes naturally evolved and developed through the coding process and through the course of reading and re-reading the data set.

Open coding is drawn from the grounded theory method and is the analytic process by which concepts (codes) to the observed data and phenomenon are attached during qualitative data analysis. It is one of the 'procedures' for working with text as described by Strauss and Corbin (1990). Open coding aims at developing substantial codes describing, naming, or classifying the phenomenon under consideration. The interview recordings were transcribed and checked for accuracy.

After broad reading of the transcripts and writing memos, a qualitative codebook and preliminary model of potential relationships and patterns were developed in preparation for analysis. The transcripts were then entered into NVivo 11 a popular qualitative data analysis computer software programme. NVivo 11 served as a platform for thematic analysis of the interviews.

3.6 Methods for Phase 2 (Quantitative)

3.6.1 Sample

In quasi-experimental pre and post-test research design, the purpose of sampling is to collect valid and reliable data from a subset of the population that would be representative of the wider population under study (Teddlie and Tashakkori, 2009). The aim is that the findings are generalizable to the population under study. The representativeness of the sample and the generalizability of findings depend on at least four factors, the size and the characteristics of the sample, the methods of sampling, the setting where the study was carried out and the response rate (Creswell and Creswell, 2020).

Purposive sampling was used to select a larger population of mental health nursing students that were available and could be studied (those who would be undergoing the crisis intervention workshop that used Forum Theatre techniques). There was a population of n= 175 targeted for this phase, n=162 attended the workshop and completed the questionnaire, n= 9 were excluded from the final analysis due to being incomplete, therefore n=153 were included for data analysis. The eight participants who were involved in the first qualitative phase did not take part in the second phase as this could have affected validity. Table 7 provides an overview of the phase 2 sample including their gender, age ranges and number per workshop.

Table 7: Phase 2 participants

Phase 2 Participants												
Gender	Female			Male			Total					
Total Number Completed	115			47			162					
Percentage	72%			28%			100%					
Age 21 - 30	36			10			46					
Age 31 - 40	38			14			52					
Age 41 - 50	32			13			45					
Age 51 - 60	11			8			19					
Per Workshop	1	2	3	4	5	6	7	8	9	10	11	12
Male	4	5	5	2	3	4	5	3	4	5	4	3
Female	10	9	8	12	12	11	8	10	10	7	8	10
Age 21 - 30	4	6	2	3	5	3	6	5	3	3	3	3
Age 31 - 40	5	4	5	4	3	5	4	4	5	4	4	5
Age 41 - 50	2	2	4	6	6	5	2	2	4	3	5	4
Age 51 - 60	3	2	2	1	1	2	1	2	2	2	0	1
Total per workshop	14	14	13	14	15	15	13	13	14	12	12	13

- n=162 completed the Jefferson Scale of Empathy
- n=9 Jefferson Scales of Empathy were incomplete and unsatisfactory for analysis
- n=153 Jefferson Scales of Empathy were satisfactory for analysis

3.6.2 Quantitative data collection

The quantitative data collection method had to be chosen based on the findings and interpretation of the qualitative phase as per the exploratory sequential design (Creswell, 2014). The qualitative findings suggested that Forum Theatre increased understanding and sense of empathy in participants, therefore the impact of Forum Theatre on empathy was explored for

phase two of the study using the Jefferson Scale of Empathy (Hogan, 2016) pre and post Forum Theatre intervention.

The Jefferson Scale of Empathy was be used as a confirmatory measure for the findings from phase 1. This was achieved by a higher number of participants undertaking a Forum Theatre workshop based on crisis support for a patient experiencing mental health distress. The same workshop was used as in phase 2 as the one used in phase 1. The workshop was a classroom-based Forum Theatre session based on a crisis intervention scenario with a fictional character 'Sam Jones'. Sam Jones was 33 years old, lived alone, and had a long history of mental illness stemming from childhood trauma that included emotional, physical, and sexual abuse at the hands of his father (Appendix 1; Chapter 3, section 3.5.3).

For phase 2 the workshop was delivered twelve times over a three-month period with a total n=162 attending with group sizes ranging between 12 and 15 per group (Table 7). Demographics recorded on the Jefferson Scale of Empathy included gender and age range (Table 7). The same Joker and two actors who were used in phase one were used in phase two for consistency of the scenario and portrayal of the patient. The Joker and the actors had been prepared with the brief (Appendix 1) and in person by the researcher for any questions and clarification. Participants completed the Jefferson Scale of Empathy before and after the session. The completed rating scales were then prepared for data analysis.

3.6.3 Measures

Before the Jefferson Scale of Empathy was developed there was not a robust psychometric scale available for measuring empathy in the context of health professionals education and patient care (Yu and Kirk, 2009). There are some empathy measures available and used in

healthcare such as the Interpersonal Reactivity Index (Davis, 1983); the Empathy Scale (Hogan, 1969); and the Emotional Empathy Scale (Mehrabian and Epstein, 1972). However, these instruments lack 'face' and 'content' validity in relation to capturing the essence of empathy in health professional's education and patient care (Ward *et al*, 2009; Hojat *et al*, 2018). These rating scales were developed for use with the general population and not specific enough and there remained a need to develop a content-specific and context-relevant empathy measuring instrument (Hojat, 2016). The Jefferson Scale of Empathy was developed to address that need (Hojat *et al*, 2001b, Hojat *et al*, 2002b).

Development, Validity and Reliability

The Jefferson Scale of Empathy was identified as currently the most widely researched and used measure of empathy in health education research (Hojat, 2016). It has been translated into 56 languages, and used in more than 80 countries (Valentin *et al*, 2019). There was a wealth of evidence reported in samples of health professional students and practitioners in support of the psychometrics of the scale, both during the period of its initial development and the two decades, since by researchers across the world (Fields *et al*, 2011; Hojat *et al* (2002a); Hojat *et al*, (2002b), Hojat *et al*, 2001b; Hojat *et al*, (2002b), Hojat and LaNoue, 2014; Hojat, 2016; Hojat *et al*, 2019).

Face validity was used in the development of the scale and consensus has been established that the items on the scale do measure empathy (Hojat *et al*, 2001b). Construct validity was obtained by factor analysis and gender comparison (Hojat *et al*, 2002a; Hojat *et al*, 2002c; Hojat and Gonnella, 2015) The scale provides acceptable levels of convergent and discriminant validity, and high levels of internal consistency and sensitivity to change (Hojat, 2016; Hojat

et al, 2018; Stansfield *et al*, 2016). Testing validity by comparing contrasted groups has demonstrated a gender difference, with female health professionals and students obtaining significantly higher scores on the Jefferson Scale of Empathy than males (Fjortoft *et al*, 2011; Hojat *et al*, 2001a, 2002a; Hojat, 2018; Sevrain-Goideau *et al*, 2020). This aligns with a long-standing consensus in the literature that indicates how female behaviour is generally more empathising than males. This phenomena has been linked to social learning, genetic predisposition and evolution (Christov-Moore, 2014; Baron-Cohen, 2003; Hojat, 2016; Hoffman, 1977; Smith, 2006).

The scale

The Jefferson Scale of Empathy is a 20-item instrument specifically developed to measure empathy in the context of health professionals education and patient care for administration to health professions students and practitioners (Hojat, 2016). Items are answered on a 7-point Likert-type scale (1 = Strongly Disagree, 7 = Strongly Agree). Half of the items are positively worded and directly scored, and the other half are negatively worded (reverse scored). The range of possible scores runs from 20 to 140 points. The highest scores are associated with a greater degree of empathy (Hojat, 2016). There is no time limit to the scale, and it takes approximately five minutes to complete. Permission to use the scale was sought and given from Jefferson University in the United States (Appendix 8), however, the researcher does not have permission to publish images of the scale itself in the thesis due to copyright. The researcher can provide a sample item from the scale provided in Figure 3.

'I try to imagine myself in my patient's shoes when I provide care for them'						
1	2	3	4	5	6	7

Strongly disagree *Strongly agree*

Figure 3: Sample item from the Jefferson Scale of Empathy

The Jefferson Scale of Empathy was conceptualised as a multidimensional construct comprised of three related factors that included 'perspective adoption' (linked to cognitive empathy), 'compassionate care' (linked to the ability to communicate empathy) and 'walking in patient's shoes' (linked to the ability to connect emotionally to the patient experience), (Hojat *et al*, 2001b; Hijat, 2002a; Hojat, 2016). While the Jefferson Scale of Empathy does encapsulate the three dimensions just mentioned in its design it does not contain subscales for each area and was developed to be completed in its entirety with a minimum of 16/20 (80%) responses (Hojat, 2016). If that number is lower than 16/20 (80%) that data must be excluded from analysis.

Normative scores and cut off values

While there have been several studies that have aimed to develop proxy normative scores and cut off values for the Jefferson Empathy Scale, the biggest and most cited are by Hojat and Gonnella, (2015) and Hojat *et al*, (2018). In these studies data was gathered over an eleven year period and aimed to provide typical descriptive statistics and score distributions for the scale. Normative score distributions of the Jefferson scale of empathy tended to be moderately skewed and platykurtic. Women obtained a significantly higher mean score (116.2 ± 9.7) than men (112.3 ± 10.8) on the Jefferson Empathy Scale ($t_{2,635} = 9.9$, $p < 0.01$). The tentative cut-off score to identify low scorers was ≤95 for men and ≤100 for women. This data was used for comparison with the results of the current research study.

Administration of the Jefferson Empathy Scale

The Jefferson Scale of Empathy was administered in paper form before and after a four-hour Forum Theatre workshop (Appendix 1) that focused on supporting a patient, played by an actor, who was experiencing a mental health crisis. This was the same scenario as used in phase 1 but delivered in twelve separate workshops over a three-month period to reach a greater number of participants (Table 7) that used the same two actors and joker as phase 1 for consistency (Chapter 3.5.3).

3.6.4 Quantitative data analysis

Preparing the data for analysis

To prepare the quantitative data for analysis it was converted from its raw state by assigning numeric values to each of the responses, counting the scores and cleansing any entry errors (Creswell and Creswell, 2020). Nine of the scales had to be removed from the analysis stage as they were incorrectly completed with several questions unanswered. The minimum number of items answered on the Jefferson Scale of Empathy for the results to be valid is 80% (Hojat, 2016). The SPSS (v27) Statistics analysis software package was used for preparation and statistical analysis of the data. The next stage was to explore the data, initially by inspecting it and carrying out a descriptive analysis to establish the mean, median, mode, range, and standard deviation of the scores to find general trends, check distributions of the data (Creamer, 2017) and compare to the Jefferson Scale of Empathy proxy normative scores and cut off values (Chapter 3, section 3.6.3).

Frequency analysis and descriptive statistics

Frequency analysis and descriptive statistics were performed in SPSS (v27) to establish occurrence of gender, age range, establish mean empathy scores, standard deviation pre-post intervention and score distributions. These were then compared to the proxy normative scores and cut off values for the Jefferson Scale of Empathy (Hojat and Gonnella, 2015). The next stage of analysis involved identification of an appropriate statistical test to analyse the data and address the question for phase 2, 'Is there a significant difference in sense of empathy for others before and after engaging in Forum Theatre?' The aim was to describe trends with view to confirming the empathy theme from the phase 1.

Assumption of normal distribution

Assumption testing for a statistical test determines whether reliable conclusions can be drawn from the results of that test and inform which tests to use for analysis (Field, 2018). Assumption of normality of distribution was analysed using the Shapiro-Wilk test which compares the cumulative distributions of two data sets (Field, 2018). These tests report the maximum difference between the two cumulative distributions and calculate a P value from that result and the sample sizes (Field, 2018). The score distributions were also observed subjectively on the histograms and boxplot outputs from SPSS (v27). The pre and post scores were not normally distributed and therefore non-parametric equivalent tests needed to be used for the data analysis stages. Parametric tests such as a matched paired t-test would not provide reliable results as the assumption of normality of distribution was not met (Pallant, 2020).

In light of the abnormal score distributions non-parametric tests were conducted to check whether there were significant differences in the empathy score between pre and post Forum

Theatre workshop and whether gender had any significant effect on the relationship between pre and post-empathy score.

Comparing mean empathy scores

To compare the mean empathy scores before Forum Theatre, the Wilcoxon Signed Ranks test was conducted. The Wilcoxon Signed Ranks test can be used to determine the location of a group of samples or to compare the locations of two populations using matched samples (Field, 2018).

Partial correlation and homogeneity of variance

A non-parametric partial correlation test with the help of the SPSS (v27) syntax editor was used to explore the relationship between pre and post-empathy score, while controlling for gender to establish whether it was confounding the results. Levene's was used to test homogeneity of variance as the data was abnormally distributed.

Levene's test was useful to check the assumption of equal variances before running what was initially going to be the One-Way ANOVA to analyse variance to compare the means of pre and post-empathy scores and gender. This was to determine whether there was statistical evidence that the associated population means were significantly different (Field, 2018). At least one of the key variables failed to pass the assumption for homogeneity of variance which implied that parametric testing such as using One-Way ANOVA would have been insufficient for drawing reliable conclusions (Pallant, 2020). The use of a comparable non-parametric test was therefore required and as a result, the Kruskal Wallis H test was used for analysis of variance (Field, 2018).

Analysis of variance

The Kruskal-Wallis H test (sometimes also called the "one-way ANOVA on ranks") is a rank-based non-parametric test that can be used to determine if there are statistically significant differences between two or more groups of an independent variable on a continuous or ordinal dependent variable (Hinton, McMurray and Brownlow, 2014). It is considered the non-parametric alternative to the one-way ANOVA (Field, 2018). The non-parametric Kruskal Wallis H test was therefore used to compare the mean empathy scores measured between male and female for both pre-and post-test results.

Interpretation

Conclusions were made based on the phase 2 results and comparison to the proxy normative data scores and cut off values (Hojat and Gonnella, 2015; Hojat *et al*, 2018) to answer the phase 2 research question; Is there a significant difference in sense of empathy for others before and after engaging in Forum Theatre? Figure 4 provides an overview of the data analysis procedures.

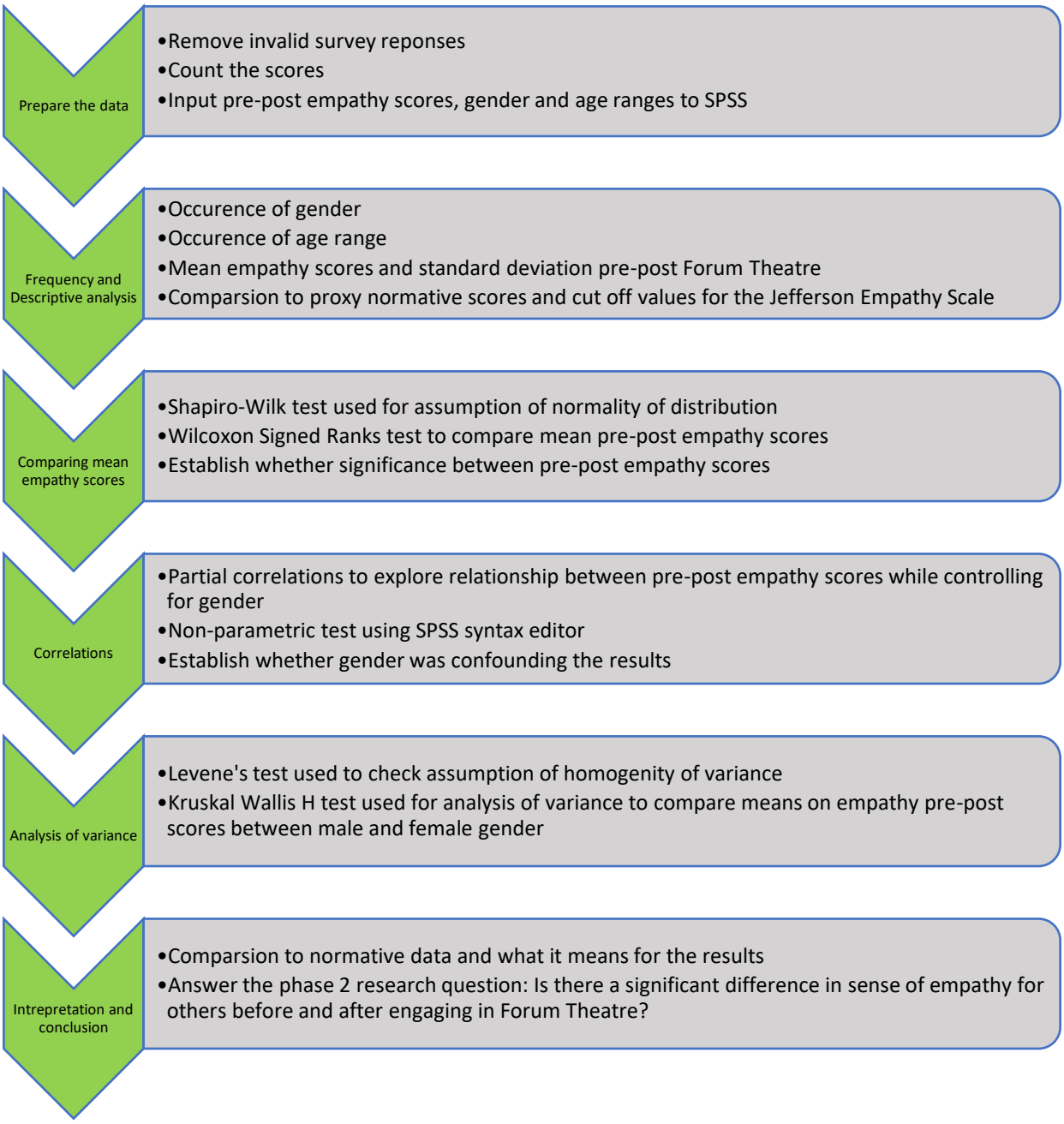

Figure 4: Quantitative analysis procedures

3.7 Interpretive Stage

Following the qualitative and quantitative phases, the connected results of the two methods were interpreted to see how they answered the mixed methods question through demonstrating how the quantitative findings have built upon the qualitative findings. The use of both qualitative and quantitative data collection methods in a single study is not sufficient to categorize a study as 'mixed methods.' It is in the integration or linking of the two strands of data that defines mixed methods research and highlights its value. Integration can happen at multiple levels of a study, design and methods level or interpretation level (Creswell, 2014).

3.7.1 Integration

The integration of the methods is inherent in the QUAL-quant sequential research design used in this study because the phase 2 question and instrument are developed and chosen based on the emergent data from phase 1. The results from the first phase of the research were used to connect and build the second stage of the research design. For this study the overarching phenomena that emerged from the phase 1 interview data was an increased sense of empathy from mental health nurses who had engaged in Forum Theatre. Phase 2 was designed to measure that sense of empathy in a bigger sample of the population with view to confirmation and transferability of the phase 1 results.

3.7.2 Joint display analysis

Drawing on Fetter's (2019) steps on the iterative process of joint display analysis; themes, patterns, and anomalies were identified in the results based on the findings of both data sets. A joint display allowed key examples from the phase 1 and phase 2 data strands to be brought together to visually display meta inferences. It should be noted that this procedure was not

necessary for a sequential exploratory design and is more often seen used in concurrent or triangulation mixed methods analysis, where the data strands have been collected independently, not already connected in anyway and mixed at the final stage. However, the researcher felt that the joint display was warranted as a user-friendly way of visualising the connected mixed methods results.

The process of building and rejecting multiple iterations of the joint display provide an opportunity to compare quantitative and qualitative data, to arrive at an optimized understanding of the mixed findings. Sample quotes from the qualitative interviews were compared to results from the statistical analysis of the survey data and connected to answer the mixed methods research question 'What conclusions can be drawn from the analysis about the application of forum techniques?'. These conclusions were then explored in depth in the chapter six discussion. Table 8 provides an overview of each stage of the exploratory sequential design with its objectives, questions and sample data collection and analysis methods.

Table 8: Sequential design, aim, objectives, questions, and methods

Phase	Objective	Question	Sample	Data Collection	Data Analysis
Phase 1 Qualitative	To explore the individual experience of mental health nurses who undertake training that employs Forum Theatre techniques To analyse the experience in relation to specific skill sets	How is Forum Theatre experienced? What specific skill sets are addressed by Forum Theatre techniques?	8 x Mental health nursing students – Maximal Variation	Semi-structured interviews	Qualitative Descriptive Approach using thematic analysis. Steps: Familiarisation Initial coding Generate themes Review themes Create thematic map Define themes
Interpretation from phase 1 to inform choice of valid and reliable measure for next phase					
Phase 2 Quantitative	To examine the impact of the application of skills acquired during a simulated practice scenario	Is there a significant difference in sense of empathy for others before and after engaging in Forum Theatre?	153 x Mental health nursing students - non-probabilistic sampling strategy	Rating scale: identified based on outcome of phase 1 as Jefferson Scale of Empathy	Frequency and Descriptive analysis. Shapiro-Wilk to test assumption of distribution. Wilkinson Signed Ranks test to compare means. Partial correlations test controlling for gender. Levene's homogeneity of variance test. Kruskal Wallis H test to analyse variance.
Interpretation (Answering the mixed methods question)	What conclusions can be drawn about the application of theatre techniques? And achieve aim: To understand the effectiveness of Forum Theatre techniques on mental health nursing students.			Findings from connected phase 1 and phase 2 data	Joint Display Analysis of the connected data and narrative in discussion

3.8 Validity and Trustworthiness

A practical approach to validity was taken for the purpose of this project with the focus on strategies through each of the stages of the data collection, data analysis and mixed methods interpretation (Johnson and Onwuegbuzie, 2004). This approach enabled the researcher to address validity issues in each stage of the design (Creswell and Plano--Clarke, 2017; Tashakkori, Johnson and Teddlie, 2020). Table 9 provides an overview of threats to validly and counter strategies used to mitigate before they are explained in more depth in the rest of this section.

Table 9: Threats to validity and counter strategies

Threats to validity	Strategies to reduce threat
Data collection stage	
Selection of inappropriate participants for either of the qualitative or quantitative phases.	The individuals who were interviewed in the qualitative phase were not selected for the quantitative phase.
Using inappropriate sample sizes for either the qualitative or quantitative phases.	The qualitative phase was a smaller sample n=8. For the quantitative phase a much larger sample was used n= 153.
Validity and reliability of measure/rating scale used in quantitative phase.	The Jefferson Scale of empathy has undergone rigorous procedures in testing its trustworthiness.
Data analysis stage	
Following up on poorly analysed or the wrong qualitative results in the quantitative stage	Ensure clarity of major theme (empathy) that was followed up in the quantitative stage.
Interpretation stage	
Comparing two sets of data when the intention is to connect and build rather than merge.	Interpret the qualitative and quantitative findings independently to answer the mixed methods question.
Interpreting the data sets in the wrong sequence	In an exploratory sequential design, the qualitative is first followed by the quantitative.
Researcher unconscious influence and bias	Use reflexive techniques to reflect and evaluate at every stage to raise awareness of how researchers own values, opinion and experiences can be positive and can inform the study but need to be considered in relation risk of researcher bias.
Lack of participant feedback on results for their opinions and confirmation of findings	Focus group provided so that participants had an opportunity to review, check accuracy and discuss the analysis of the semi-structured interview data.

3.8.1 Data collection stage

At the data collection stage, it was essential to select the appropriate participants for each phase of the study. It was important that individuals who were interviewed in the qualitative phase were not selected for the quantitative phase. Furthermore, the appropriate sample size needed to be selected for each phase to ensure validity of the data in analysis. A smaller sample would be required for the qualitative phase interviews and a much larger sample for the quantitative phase. The selection of a valid and reliable measure for the phase 2 was vital and the Jefferson

Scale of Empathy was chosen both for its suitability for the study and for the fact it is tried, tested, and undergone rigorous procedures that have taken place to ensure trustworthiness.

3.8.2 Data analysis stage

At data analysis stage it was important that the theme followed in the phase 2 stage had been properly analysed using an established method. The interpretive stage of this study could easily be misunderstood, it was important to remember that this is a sequential exploratory design and that the mixing of the methods occurs in the connecting and building of the data, rather than the merging of data as would be seen in a concurrent design.

3.8.3 Interpretation stage

A joint display analysis has been used to present the connected data and conclusions, however, has not been used to merge the data as this is a sequential rather than convergent design. Finally, it was important that the participants were able to receive the opportunity to review, check accuracy and discuss the analysis of the semi-structured interview data, and therefore a focus group was arranged to provide this opportunity. Further inferences were made through discussion of the meaning of the mixed methods findings.

3.8.4 Reflexivity

Through practicing reflexivity to question the process and practice of research, the validity and trustworthiness of the study was strengthened. Reflexivity encourages the consideration of methodological conduct and theoretical assumptions of the researcher (Lumsden, 2019). The process raises awareness of how philosophical positioning influences what counts as knowledge or social reality (Haynes, 2012). This can lead to new insights and questions the findings and output of a study (Reid *et al*, 2018).

Field notes were collected and recorded in a diary. There are extracts at the end of each chapter which provide insight into that journey. Keeping a diary and taking time out to think about his place in the research was helpful for maintaining the researcher's wellbeing, and allowed the time to consider how his personal background and traditions of the nursing field could influence the way the research was implemented. The process allowed the researcher to become more aware of when they were constraining or enabling, valuing, or rejecting, forms of knowledge produced during the study, thus increasing his accountability as a researcher (Haynes, 2012).

3.9 Ethical considerations and approval processes

The well-being of participants in a research study is paramount and comes before the need to answer questions, therefore ethical considerations must be taken onboard at every stage of the research process (Wisker, 2008). In relation to this project the ethical standards and processes required are well documented by the Health Research Authority (HRA, 2016), and the University of West London's Research Ethics Policy (UWL, 2015).

Approval was sought at two stages prior to the qualitative data collection and then was reviewed and re-approved (Appendix 9) for use of the Jefferson Scale of Empathy (Hojat, 2016) in phase 2. Permission was requested and granted to use the scale from Jefferson University (Appendix 8). The approval was required through the university research ethics approval committee in line with the university research ethics governance policy (UWL, 2015), and Research Ethics Code of Practice (UWL, 2014). The scrutiny of this process allowed for further critical appraisal of ethical issues. Approval was not required via the NHS Health

Research Authority (HRA, 2016) as there was no work undertaken in clinical areas or with patients, carers, or families.

Before approval was sought a risk assessment was made to determine the level of risk the study might pose to participants psychological, physical, or social wellbeing. The research proposal was considered minimal risk as participants were unlikely to be exposed to anymore stress than they would experience in their daily working lives. However, there was potential for some emotional impact on participants when role-playing challenging situations that were representative of the difficult jobs they do.

To address potential emotional impact facilitators moderated the Forum Theatre sessions providing regular debriefs to support the participants emotionally. Furthermore, it was inherent to the Forum Theatre techniques that participants are supported by the Joker throughout and so any early warning signs of anyone becoming distressed would have been acted upon (Boal, 1974).

The semi-structured interviews of the qualitative stage of the research had potential to be emotive because this approach to enquiry takes the researcher in to the real-world emotions of the participant. The researcher in this case, as an experienced mental health nurse, has highly developed skills in consulting with people who display a range of emotions and would be able to signpost to other sources of help if issues had arisen.

Participant information sheets (Appendix 5) and informed consent forms (Appendix 6) for Phase1 and Phase 2 were given to all participants prior to their agreement to be voluntarily

involved in the study. These forms provided a full explanation of the purpose of the project, possible outcomes of their participation, and how confidentiality would be maintained.

A focus group (Chapter 4, section, 4.2) was arranged, with permission from the eight participants who were interviewed to share the results and discuss their thoughts in relation to the interpretations of the interview data.

3.10 Summary

This chapter has discussed the researcher's journey through methodological considerations, it aligned the researcher and study with a pragmatic world view and through this explains and justifies the choice of mixed methods. Through a close examination of the aim, objectives and questions the researcher applied the two-phase sequential design. From there the researcher outlined the choice of methods; semi-structured interviews and thematic analysis through a qualitative descriptive approach which would inform the choice of quantitative measure ahead of descriptive analysis, mixing of methods, and interpretation. Furthermore, how the researcher addressed issues of validity in each stage of the design have also been outlined. Finally, consideration has been given to ethical implications and approval processes.

3.10.1 Collaborative partners

Collaborative partners include the clinical director of mental health services, deputy director of nursing, clinical education team and head of urgent care services from Berkshire Healthcare NHS Foundation Trust. The collaborative partnership was built upon shared goals of contributing to the body of knowledge around mental health nursing practice and the learning and development strategy of the trust.

3.10.2 Site considerations

In certain areas of research, it can be crucial to consider the site where the work will take place both in terms of the methodology employed and potential issues with the site itself. In the case of this study, there were no issues around the site of the research as it took place in basic classrooms and permissions were sought alongside the ethical approval process.

3.11 Field Notes

(Researcher field notes, November 2018)

I have continued to wade through a vast epistemological and ontological debate in my mind, and as I do this, I am a little concerned that I have gone rogue from my colleagues on the Professional Doctorate. They have all taken the route of Action Research, and I feel a little alone. There is a lot to be said for that debate and the moral support that can be had from taking a similar approach. Ironically, it may even be easier to justify an Action Research methodology as Forum Theatre literately represents the underpinning principles. Thinking I may have just made it harder for myself?

From the outside it would make more sense to research Forum Theatre through the lens of critical theory, with the view that knowledge is power and understanding how a person is oppressed enables them to take action to change oppressive forces. In a more practical sense, I keep coming back to the idea that the way we are using Forum Theatre isn't completely about challenging oppressive forces with the aim of social change. The approach we were using is about individual change, development, and improving/challenging practice in teams. I therefore, keep returning to pragmatism and mixed methods as I think it will allow for more flexibility. Furthermore, it is important to me that I can get measure of impact. I believe passionately in what is possible with Forum Theatre and want to achieve a completeness to the study. It would be great to have some unequivocal outcomes, whatever they may be.

I genuinely want to get a better understanding of the experience of mental health nurses in Forum Theatre. Ultimately, I understand how Forum Theatre might be useful to mental health nursing students and whether their experience was something we could say was replicable within the profession. This would provide an evidence base to allow us to include it in learning and teaching strategies more formerly in the future. It is exciting to be getting closer to data collection after all the thinking and talk!

Chapter 4 Analysis and Results

4.1 Introduction

This chapter provides an account of the how the analysis was conducted for phase 1 and 2 of the research and presentation of the results. The qualitative phase 1 objective was to explore the individual experience of mental health nurses who undertake training that employs Forum Theatre techniques and to analyse the experience in relation to specific skill sets. Data was collected through semi-structured interviews with eight mental health nursing students who had undertaken a Forum Theatre workshop. The interviews were thematically analysed using Braun and Clarke's (2006) six step method to answer the research questions: 'How is Forum Theatre experienced?' and 'What specific skillsets are addressed by Forum Theatre Techniques?'

The Quantitative phase 2 objective was to examine the impact of the application of skills acquired during a simulated practice scenario. The results of phase 1 were used to inform the selection of the Jefferson Scale of Empathy (Hojat, 2016) to measure pre-post Forum Theatre intervention empathy scores to answer the research question: 'Is there a significant difference in sense of empathy for others before and after engaging in Forum Theatre?'

The chapter concludes with the mixed method results being presented through a joint display analysis addressing the mixed methods research question; 'What conclusions can be drawn from the application of Forum Theatre techniques?' The results are discussed at depth in chapter six.

4.2 Phase 1 Qualitative Analysis and Results

This part of the study used the data collected via semi-structured interviews, to explore the individual subjective experience of participants who had taken part in a Forum Theatre session based around patients who were experiencing a mental health crisis. Braun and Clarke's (2006) six step process for analysis led to revealing four main themes: Authenticity, Learning Environment, Active Learning and Personal Development, plus three subthemes; Communication Skills, Resilience and Empathy. This section explains how the themes were generated and illustrates them in a thematic map (Figure 5). The themes are then discussed in relation to the research questions and literature. This phase reveals how participants in Forum Theatre, in essence, gained an increased sense of empathy, and why that would form the basis for phase 2 testing.

4.2.1 Participants

For phase 1 eight participants were recruited via email invitation based on a purposeful sample, they were pre and post registration mental health nursing students on a four-hour crisis intervention training course that used Forum Theatre techniques (Appendix 1; Chapter 3, section 3.5.3). Selection for interview was based on a maximal variation strategy by recruitment of participants who offered a range of age, experience, qualification levels and were equally represented by males and females (Chapter 3, section 3.5.1). Ages of participants ranged from a minimum of 26 years old to maximum of 51 years old with a mean age of 38 and a maximum age range difference of 25 years. Practice experience ranged between undergraduate (3 years) to registered nurses (20 years). Qualifications ranged from Higher National Diploma (academic level 5) to Masters (academic

level 7) and included two undergraduate nursing students. The Semi-structured interviews took place approximately three months after the Forum Theatre Workshop in a private meeting room at the university. Table 10 outlines the participants gender, age, experience, education level, date of workshop undertaken, interview date and interview length.

Table 10: Phase 1 participants

Phase 1 Participants						
Participant number	Gender	Age	Experience (years)	Education level	Interview date	Interview length (mins)
P1	Male	51	20+	Diploma HE	18.04.19	47
P2	Male	28	5	BSc	10.04.19	35
P3	Male	35	3rd year BSc	Level 5/6	17.04.19	42
P4	Female	44	3	BSc	10.04.19	37
P5	Female	47	12	MSc	24.04.19	58
P6	Female	26	3rd year BSc	Level 5/6	17.04.19	43
P7	Male	39	16	MSc	24.04.19	41
P8	Female	35	10	Diploma HE	11.04.19	55

- Semi-structured interviews took place approximately three months after the Forum Theatre Workshop which took place during January 2019
- All interviews took place in a private meeting room at the Berkshire Institute for Health in Reading
- All participants had attended one four-hour Forum Theatre workshop based on mental health crisis intervention
- Participants were recruited based on maximal variation and invitation

4.2.2 Initial thoughts

Immersion in the data began with the process of transcribing the interviews. During the transcribing, notes were taken when the researcher noted phenomenon of interest to the research questions. The transcripts were then uploaded to NVivo 11 and re-read with notes made of initial thoughts and reflections in relation to the research questions. Initial notes were linked to potential codes/themes at this stage and throughout it was important to be aware of my assumptions and their influence on interpreting the interview data.

Table 11: Example of initial notes and reflection

Initial Notes	Potential codes/themes	How related to research questions?
Many comments about quality of acting	Realism	Subjective experience
Asking difficult questions	Communication	Specific skillsets
Seeing reactions from actor	Live observation	Subjective experience
Sense of being immersed in the scenarios	Engaged learning	Subjective experience
Becoming more aware	Reflection	Subjective experience + specific skillsets
Care and compassion – patients perspective	Empathy	Subjective experience + specific skillsets
Comparisons to role-play	Structure of Forum Theatre	Subjective experience
Increased confidence	Valued	Skill sets impact on practice
Feeling comfortable and safe to learn	Facilitation	Subjective experience
Personal reflection on reading the transcripts; *'It is important that I am mindful as I enter into the analysis of my own filters. I have had a keen interest in this topic for several years now and have been immersed in delivering Forum Theatre in many areas of healthcare and therefore have some quiet established assumptions on how it is experienced. It was useful to make a note and bracket my assumptions before stepping into the analysis so that I could be aware of them and refer to them to maintain objectivity and hear the voice of the participants through the interviews. Furthermore, as a mental health nurse of many years I had to be aware of the risk of over identifying with the participants when reading the transcripts'.*		

As shown in Table 11 some initial codes had started to form and potential links such as the quality of the acting compared to usual role-play scenarios, and a link to quality of acting and engagement in the learning process. The next stage was to read through the transcripts again and code in NVivo 11 to generate a clearer picture of the themes.

4.2.3 Preliminary themes and codes

The data set of eight interviews were carefully read through several times with each phrase or segment of text that held meaning being attached to a code. Initially this could have been deemed rather arbitrary, with a focus on more obvious semantic codes, though one-word codes were avoided where possible to allow more room for understanding and interpretation to be drawn.

Many of these codes held deeper relevance, the process of becoming immersed in the data, critically reflecting upon it and sorting, and attaching latent codes with more implicit meaning led to some merging of categories, and preliminary themes were generated as shown in Table 12. It was important at this stage to not jump straight into themes, and through the process of time and reflection to look for the interpretations, clustering together the codes to generate the themes (Braun *et al*, 2019; Nowell *et al*, 2017).

Table 12: Preliminary themes and codes

Preliminary themes and codes	Active participation	Reflection	Learning environment	Realism	Communication skills
Preliminary themes and codes	*Taking part/trying out with actor – rehearsal* *Modifying approach* *Shared challenges* *Sharing of ideas* *Observation* *Engagement in Forum Theatre process* *Practicing interactions* *Giving feedback* *Acting on feedback* *Personal Investment*	*Feedback and feedforward* *Reflection in and on action* *Tailored – personalised learning* *Actor 'in role' feedback* *Modifying approach* *Draws on real experience* *Becoming more self-aware* *Managing own emotions - Self-regulation* *Confidence* *Resilience* *Being challenged* *Understanding the patient* *Observing others. (getting it wrong or right)* *Engagement in Forum Theatre process* *Personal investment*	*Theory to practice* *Safe learning* *Facilitation style – inclusivity* *Facilitation – safe/containing* *Feeling safe* *Focus on individual* *It's okay to make mistakes* *Draws on theory* *Honesty* *Tailored – personalized learning* *Type of learning compared to other styles e.g. role play*	*Being challenged* *True to practice* *Personal relevance* *Quality of acting* *The scenarios representing practice* *Emotional response of actors* *Feeling anxious to help* *Honesty* *Internal emotional processes and responses to the actors* *Reproduces real experience*	*Having difficult conversations* *Communicating care* *Responding to challenges* *Asking the right questions in the right way* *Understanding patient's perspective* *Seeing how our communication impacts on others* *Transferable skills* *Active listening skills* *Understanding patient's perspective* *Emotional regulation to help patient* *Working through uncomfortable feelings* *Empathise with patients* *Asking the right questions in the right way* *Increasing self-awareness* *Feeling more confident* *Non-verbals and body language* *Managing conflict*

The codes were examined to identify where there were strong relationships or patterns that had enough significance to be turned into broad themes that had something to say about the research questions, for example, 'Reflection'. It was anticipated but not assumed that there might be interplay between the themes, and thus natural that codes may relate across some themes albeit within that different context.

Consideration was given to the fact that all participants had shared the same type of intervention (Forum Theatre) and therefore this was more likely to lead to overlap between codes. Also, the group were all from a mental health nursing background which could compound overlap. Where there was a clear overlap between coding and preliminary themes the codes were again examined and reflected upon, and if it was clear that they could be re-clustered into one theme this was done. An example was several codes appeared such as 'quality of acting' and 'personal relevance' which were collated into a theme called 'realism'.

At the end of this step the codes had been organised into broader themes. These indicated how the research questions on how Forum Theatre is subjectively experienced and which specific skill sets were addressed. The themes at this stage were a mixture of descriptive and interpretive which drew together patterns in the data pertinent to those research questions.

4.2.4 Refining the themes

The preliminary themes were critically reviewed so that they would begin to take more focus and align more clearly with the research questions. This was done by reviewing the data once more using NVivo 11 to re-examine associated quotes and phrases from the interviews. The themes were

reviewed for validity and reliability of concept. They were cross-checked to ensure that the data supported each theme it had been associated with across all eight interviews.

The key alterations were the reduction of five themes into four broad themes with subthemes as follows; the themes ‘Reflection’ and ‘Active Participation’ were combined to form ‘Active Learning’; The theme ‘Realism’ was changed to ‘Authenticity’ to more broadly and deeply encapsulate the participants experiences; The theme ‘Communication Skills’ was removed and replaced with ‘Personal Development’, with three subthemes ‘Communication’, ‘Empathy’ and ‘Resilience’ providing more focus and clarity. Finally, the theme ‘Learning Environment’ remained. Table 13 shows the findings from the interviews aligning the themes and sub themes in relation to the research questions. The themes were then organised into a thematic map (Figure 5) to demonstrate how they interact.

Table 13: Final themes and codes

Theme	Learning Environment	Authenticity	Active Learning	Personal Development
Codes and subthemes	*Theory to practice* *Safe learning* *Facilitation style – inclusivity* *Facilitation – safe/containing* *Feeling safe* *Focus on individual/person centered* *It's okay to make mistakes* *Modelling good practice* *Inclusivity* *Honesty* *Reassurance* *Tailored – personalized learning* *Type of learning compared to other styles eg role play*	*True to practice* *Personal relevance* *Personal investment* *Quality of acting* *Emotional response of actors* *Quality of scripts* *Connection and synergy* *Internal emotional processes and responses to the actors* *Memorable – the theatre experience* *Reproduces real experience*	*Taking part and trying out with actor - rehearsal* *Modifying approach* *Shared challenges* *Sharing of ideas* *Engagement in Forum Theatre process* *Practicing interactions* *Feedback and feedforward* *Reflection* *Observation – observing others (getting it wrong or right)* *Actor 'in role' feedback* *Modifying approach* *Draws on real experience* *Becoming more self-aware* *Being challenged* *Understanding the patient*	***Subtheme – Resilience*** *Feeling more confident* *Responding to challenges* *Working through uncomfortable feelings* *Transferable skills* *Increased reflective skill/self-awareness* ***Subtheme - Empathy*** *Seeing how communication impacts on others* *Understanding patient's perspective* *Emotional response/regulation to help* *Person centred approach* *Feeling and identifying* ***Subtheme – Communication*** *Active listening skills* *Non-verbal's and body language* *Paralinguistics* *Having difficult conversations* *Questioning techniques* *Barriers to communication*
Relationship to research question	How is Forum Theatre subjectively experienced?	How is Forum Theatre subjectively experienced?	How is Forum Theatre subjectively experienced?	What specific skill sets are addressed by Forum Theatre techniques + subjective experience

4.3 Thematic Map

The themes and subthemes were organised into a thematic map (Figure 5) that illustrates the relationships between the themes included for the narrative 'How do mental health nurses experience Forum Theatre?'

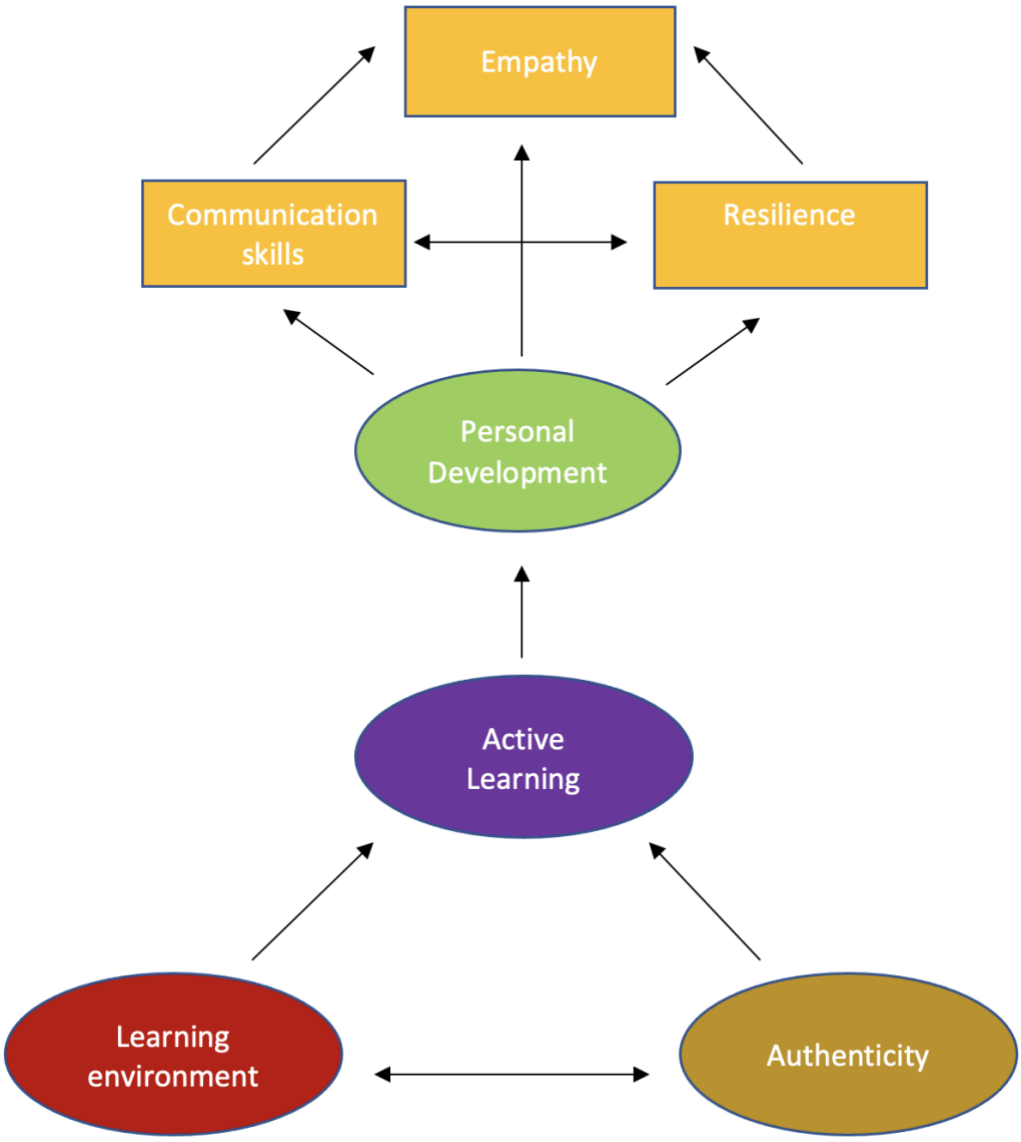

Figure 5: Thematic map

4.4 Defining the Themes and Subthemes

The four themes and subthemes generated are shown in the thematic map (Figure 3). They were then explored more deeply in relation to the two phase 1 research questions, with use of extract examples from the interview data. The interview data indicates that the four themes are interlinked, and the thematic map demonstrates the structure for how the themes interlink and support each other. All four themes and subthemes contribute to answering the research question, 'how Forum Theatre is subjectively experienced?'. The personal development subthemes of 'communication skills' and 'empathy' contribute to answering the research question 'which specific skill sets are addressed by Forum Theatre techniques?'.

Each theme was considered in relation to answering phase 1 research questions on how Forum Theatre is experienced and what changes might occur for mental health nurses who engage in Forum Theatre. Figure 6 illustrates the approach to 'telling the story', for the Phase 1 results. Themes, subthemes, and their meaning are discussed in relation to the research question with extracts from the interviews threaded throughout to provide supporting evidence. Throughout the narrative the researcher has indicated where empathy has threaded through each of the themes to result in the measurable outcome for phase 2.

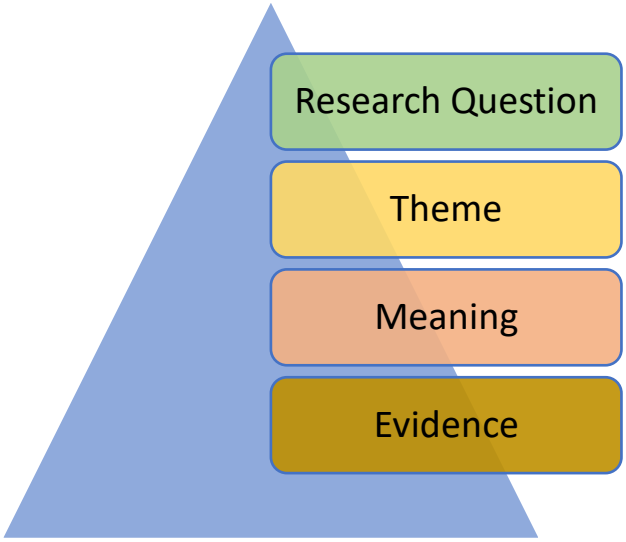

Figure 6: Phase 1 results – telling the story

4.5 Theme 1: Learning Environment

This theme was generated through participants descriptions of their experience of taking part in Forum Theatre and provides answers to the research question on how Forum Theatre is subjectively experienced. The meaning of the theme is in relation to various characteristics raised by participants that contribute to Forum Theatre being a positive learning environment.

The interviews suggest that a positive learning environment is created through the way Forum Theatre uses participatory learning to value, build trust and rapport among learners, and between the Joker and learners. The culture of inclusivity and value of one another helps establish trust and leads to an emotionally safe supportive environment. This environment enables true participation, engagement, and openness to learning, underpinned by the role of the Joker in promoting those attributes and values through use of empathic communication skills.

For some, Forum Theatre was a very different experience when compared to other learning strategies they had been involved with. Forum Theatre has its own unique structure and its use in the context of mental health nurse education was new for all the participants. Participants raised interesting ideas about the experience of the Forum Theatre learning environment.

The sense of feeling safe to learn was raised;

'The way the training is done made you feel it is a safe place to make mistakes and get it wrong. The facilitator was good to people, making you feel able to have a go and get it wrong and not feel as though you are being judged'. P6, Student Nurse, 3rd Year Pre-Registration Mental Health, Female, 26.

These comments seem to provide evidence that this participant experienced a sense of emotional safety during Forum Theatre, that she felt able to practice and make mistakes without feeling exposed or scrutinised. The comments also suggest that the Joker role is very important in creating that safe culture and space to learn within Forum Theatre. The comment about being good to people and a non-judgemental approach both model empathic understanding and behaviour contributing to the sense of safety experienced by the learners.

The sense of safety was strengthened by a supportive community of learning;

'Although the training was very challenging with the actors and everything, we felt like we were all in it together and the trainer made sure no one was made to feel humiliated themselves if we messed up with the client'. P3, Student Nurse, 3rd Year Pre-Registration Mental, Male, 35.

This comment suggests how Forum Theatre provides a supportive culture free of oppression in a Forum Theatre session which aids openness to learning. This points to good facilitation by the Joker. The sense of safety was also raised by a participant but in relation being able to practice consultations with patients (actors) without fear of causing harm to a real patient;

'*The way we can ask and ultimately in this training it won't result in getting something wrong meaning the person will do something to harm themselves'.* P5, Mental Health Nurse, Post Registration, Female, 47.

This comment suggests that the participant welcomed the opportunity to practice without the fear of causing harm to a patient. It also signifies what might be a personal fear of getting things wrong and causing harm, which the individual lives with in daily practice. Forum Theatre was compared to role-play by a participant who revealed how they felt the facilitation of Forum Theatre created a positive atmosphere for learning;

'I have done a fair amount of role-play as part of training over the years and it is always a bit scary but this was very well facilitated and created an atmosphere that was very geared towards making everyone feel comfortable to try things out'. P5, Mental Health Nurse, Post Registration, Female, 47.

This comment reveals the sense of a safe learning environment, and a sense of inclusivity created by the Joker when compared to previous training that used role-play. The Joker's role in engagement and creating a culture of safety was emerging as very important, and it might be that empathy underpins the Jokers approach to creating that safety for participants. The next

comment builds on how the experience of Forum Theatre in relation to facilitation, the role of the actor and observing others adds to the learning experience;

'The rest of the training was quite diversified in the way that the facilitator supported and the actor stayed in role, the way we got to see others try and do the scenario and learn from each other. All that actually opened up schools of thought and willingness to learn'. P4, Mental Health Nurse, Post Registration, Female, 44.

This participant appears to highlight how Forum Theatre provides an opportunity to see others attempt the same scenario with a patient who remains in role, providing an opportunity to gain different perspectives which may promote empathic understating of both the patient and peers. It also refers to the Joker as vital in facilitating this process. The personal relevance to practice seems important in the comments as it enabled engagement through empathy for the characters and other SpectActors. This comment seems to reflect that Forum Theatre felt meaningful and therefore was worth investing in as it had made a difference to practice;

'A lot of training that doesn't actually make any difference to the job it's just kind of a stressful thing that you have to get out the way to tick a box somewhere but this actually helps you in your practice'. P2, Mental Health Nurse, Post Registration, Male, 28.

When reflecting on this comment it could also indicate that the participant felt valued in comparison to previous experiences of training, where they might perceive the training to be designed to protect the organisation over an attempt to make a difference in practice.

This quote appears to suggest that the Forum Theatre workshop took them out of their comfort zone creating some anxiety, but this led to them engaging more deeply and motivating them to try and perform;

'It was quite realistic in a way and anxiety provoking but I think that anything that brings about anxiety makes you kind of perform better and want to do better whereas if you're doing with colleagues, it's not realistic'. P2, Mental Health Nurse, Post Registration, Male, 28.

The learning environment theme appeared to consist of some key concepts that contributed to how Forum Theatre was experienced, these included the role of the Joker in role modelling and creating a psychologically safe and inclusive space.

4.6 Theme 2: Authenticity

The authenticity theme emerged from the interview data and helped to answer the phase 1 research question 'how is Forum Theatre subjectively experienced?' Authenticity was established as a strong underpinning theme that supported and thread through the other themes in the experience of Forum Theatre. Authenticity is the quality of being real or true and was captured in several ways; the quality of the acting and portrayal of patients, their back stories, the Joker's understanding of complexity of communication in mental health settings, motivation, and culture to create a positive learning environment. These components contributed to authenticity in emotions, reflections, and learning through providing personally relevant scenarios and characters for participants to interact with, promoting empathic connection, understanding and communication.

Many of the participants talked about the quality of the acting in portraying a patient;

'The actor responded as a real patient would in an assessment, and so I naturally engaged with them as I would in practice without thinking about it'. P4, Mental Health Nurse, Post Registration, Female, 44.

The comment suggests that the participant was able to suspend disbelief and connect with the patient in a very real way due to their mimicking of the kind of presentation that the participant sees in practice. High quality acting that accurately represents service users who are emotionally distressed, in scenarios that are based on interactions relevant to practice, was highly significant to participants;

'I think the actors have developed the characters in the background story very well, the kind of patients we get a lot of'. P1, Mental Health Nurse, Post Registration, Male, 51.

This comment suggests how authenticity of the scenario and portrayal of the actors held personal relevance and enabled connection and engagement in the narrative. This realism and accurate portrayal seemed to go beyond the surface for a number of the participants;

'During the (role-play, sic) I almost forgot that there were other people around and it was just me and the actor, I felt the same emotions that I would with a real patient. This was because the portrayals were so real and not over the top like some role-plays I have taken part in'. P7, Mental Health Nurse, Post Registration, Male, 39.

This comment describes emotional impact on the participant, they identified with emotions they experience when working with real patients and demonstrates how there were some

powerful psychodynamics involved. This suggests that the authenticity of the scenario and portrayal evoked natural authentic emotions in the participant. This may lead to further involement and immersion in the Forum Theatre experience. Another example was how the actor could enhance reality and sense of immersion through their skill in accurate response to the participant;

'The actors were very skilled in how they improvised and went with the scenario, they altered their responses depending on how we were with them which was what I thought was very clever and innovative'. P8, Mental Health Nurse, Post Registration, Female, 35.

This comment reveals that genuine exchanges of emotions took place between the actor and the participants. It reveals that there were evolving complex dynamics taking place, generated through the accuracy of the actor portrayals and engagement of the participant. Feedback from the actors while in role was highlighted as powerful for participants;

'They have given us feedback as to the kind of questions that worked for them. What made them feel more upset, angry and on edge or kind of what calmed them down'. P2, Mental Health Nurse, Post Registration, Male, 28.

This comment seems to demonstrate how the exchange of emotions was real, and therefore the actor was able to feedback genuinely on what helped and didn't help in that situation promoting, perspective taking based on true emotions. This may have been based on a combination of accurate background information and knowledge of the role and on the feeling evoked during the encounter. However, this seems to fit well with how authenticity threads through and enhances the experience of Forum Theatre for participants.

4.7 Theme 3: Active Learning

In answering the phase 1 research question 'how is Forum Theatre subjectively experienced?' In Forum Theatre participants interact and take part both as an audience member through observations, sharing knowledge and idea's and by 'being on stage' engaged in an interaction. This process of sharing ideas, actively reflecting, problem solving, modifying and rehearsing was evident throughout the interviews. Therefore, a theme named 'active learning' was generated.

The participants commented on the conversations and observations they were part of and how they learned from different approaches;

'What we did with the actor was all taking goes doing different parts and I learnt a lot from other people and their style of asking questions and how they broached the topic of suicide and difficult issues in a subtle way'. P2, Mental Health Nurse, Post Registration, Male, 28.

This comment appears to refer to watching the Forum Theatre play unfold, with a peer asking questions of the actor in the patient role, listening, and observing what was helpful and less helpful to the patient. Then thinking about what they might use from what they had witnessed through sharing ideas. Interviewees commonly mentioned how they learned from hearing the views of others, and the exchange of ideas and perspectives between participants as active members of the audience;

'Hearing different practitioners comments about their experience when in the seat with the actor and also taking comments from practitioners observing. I learned a lot from hearing

their thought processes, their emotions and the way of approaching assessment, what questions to ask. There was something different happening and it was thought provoking'. P3, Student Nurse, 3rd Year Pre-Registration Mental, Male, 35.

This extended to an acceptance that people can take different approaches and sometimes get it wrong;

'I have learned that we all find certain situations difficult and that we all do things slightly differently'. P6, Mental Health Nurse, Post Registration, Female, 26.

This highlights how Forum Theatre provide practitioners an opportunity to gain fresh perspectives on challenging interactions and see how it is normal to struggle with them. This may promote empathy for each other and regulate the internal self-critic. Furthermore, it provided insights into common mistakes;

'I was watching others at points and realising by seeing the patients reaction how badly wrong we get it a lot of the time'. P7, Mental Health Nurse, Post Registration, Male, 39.

This comment seems to reflect on how watching a scenario unfold was revealing on how frequently and easily mental health nurses get communication with patients wrong. This comment could be interpreted in several ways but with people who are in mental health crisis it may relate to how empathy is felt and communicated from the patient's perspective. The interviewees suggest that Forum Theatre provides an interesting platform for reflective learning because participants are involved in shaping a live scenario and reflection isn't a long-drawn-out process that is overly structured and analytical, but rather it is more organic and immediate.

'I realised that I was using a lot of stock phrases that the actor picked upon and said she didn't find helpful, like I kept saying yeah I understand how hard this must be for you'. P7, Mental Health Nurse, Post Registration, Male, 39.

The participant who made this comment seems to reflect on an insight gained through Forum Theatre in relation to asking questions and perhaps using stock empathic statements. The actor had told him that this was unhelpful. It provides some evidence of the reflective process that Forum Theatre might encourage. Feedback from the actor in role was commented on;

'The actor would stay in role and the facilitator would ask the patient what it was that had made them disengage, and they would say it was the way the nurse may have asked a question or their body language'. P5, Mental Health Nurse, Post Registration, Female, 47.

In this extract the participant reports on getting feedback from the patient who has remained in role providing a reason for why they have disengaged, in this case in relation to body language that had been off putting. In this comment the focus appears to be about 'how' the nurse asks a question or uses their body language matters for the patient. This is the kind of feedback that is unlikely to be obtained in this form from a real patient and could be hindering an interaction.

4.8 Theme 4: Personal Development

There were several areas of personal development that emerged in the data which led it to being an umbrella theme to three developmental subthemes. The subthemes, communication,

empathy, and resilience all offer insights into answering the phase 1 research question, 'how is Forum Theatre subjectively experienced?'. The subthemes communication and empathy also provide results for the second phase 1 research question 'what specific skill sets are addressed by Forum Theatre techniques?'

4.8.1 Subtheme: communication

Interview data suggested that more time spent building rapport made it easier to ask difficult questions and that feedback and suggestions from the audience helped with asking questions in a useful way;

'This helps you build rapport and then use that rapport to ask the right questions in the right way'. P3, Student Nurse, 3rd Year Pre-Registration Mental, Male, 35.

The comment above seems to suggest that the participant developed skills in rapport building and asking questions. This is also demonstrated by another participant who reported how since taking part in Forum Theatre they have continued to take more time to consider their questioning before asking questions of the patient, which indicates putting the patient needs before the task of asking questions and displays an empathic communication skill;

'I think more about the questions I ask before I ask them'. P2, Mental Health Nurse, Post Registration, Male, 28.

A further example of empathic connection, understanding and communication is provided by this participant who appears to suggest that Forum Theatre has increased self-awareness and develop skills around managing uncomfortable silences with patients;

'But in a natural way they helped us be more aware of ourselves and how we interact with others I am not very good with silence and learned that I kept talking and almost overloading the actor with questions'. P8, Mental Health Nurse, Post Registration, Female, 35.

The insights were equally about non-verbal, for example, body language and personal traits that participants may not have been aware of the impact on the patient's perception of a nurse's empathic concern;

'There was one girl who didn't realise, but she was smiling a lot and pointing with her pen and this was frustrating the patient and the actor fed this back in a very nice way and it helped the nurse think about her own body language a bit, so it was often small things like that gave insights'. P7, Mental Health Nurse, Post Registration, Male, 39.

Participants talked in the interviews about how there can be a tendency sometimes to be automated, and how use of standardised assessment tools can become a barrier and prevent true engagement with patients;

'It's changing that practice really and making it personable and away from the automated robotic approach'. P1, Mental Health Nurse, Post Registration, Male, 51.

This comment appears to suggest that by establishing good rapport and exploring issues from the patient's point of view rather than being led by their own agenda, they were better able to meet their own agenda as well as that of the patient. This maybe indicates how participants learned about the importance of trying to understand a patient's inner experience and the ability

to be present in that moment with them. This is a skill that for the researcher is associated with empathic communication skills.

The use of mental health nursing 'lingo' was acknowledged by this participant who realised he had been asking questions that the patient might not understand. Adjusting the approach to suit the needs of the patients demonstrates empathic understanding and communication;

'Asking those kinds of questions that maybe don't really make sense to a normal person, you know, do you feel safe? What does that mean to a patient?' P3, Student Nurse, 3rd Year Pre-Registration Mental, Male, 35.

This sense of improved communication skills has aided assessment by allowing for a more collaborative interaction:

'I feel more skilled in this, getting to the points I need to get through in an assessment but through the patient rather than a checklist'. P1, Mental Health Nurse, Post Registration, Male, 42.

This next comment highlights how the participant was able to focus on the patients voice and perspective;

'To carry out assessment with awareness of their perspective and the way it's being conducted allows for them (the patient, ed.) to be heard' P5, Mental Health Nurse, Post Registration, Female, 47.

This comment seems to show a distinct increase in awareness on how a practitioner's own agenda can cloud their practice and therefore negatively impact on an interaction such as an assessment. Furthermore, this demonstrates an enhanced awareness of the importance of the patient voice and ability to emphasise through understanding and communicating.

The communication skills that appear to be the focus for participants mainly seem to relate to those that support rapport building, engagement and understanding. There is evidence of the importance of paralinguistics, for example; 'how' questions are asked, use of non-verbal communication, questioning techniques and those that put the patient at the centre of the intervention. Underpinning this appears to be the thread of skills which can be used to demonstrate empathy. This seems to make sense in this context because the scenarios are about supporting somebody who was very distressed.

4.8.2 Subtheme: resilience

The interviews revealed that often the participants had left Forum Theatre feeling empowered, confident and resilient in themselves as practitioners;

> *'From feedback from actors, from colleagues, from your experience watching colleagues and watching actors respond. It improves confidence and refines, you know, helps you become a better practitioner'.* P4, Mental Health Nurse, Post Registration, Female, 44.

The participant in this extract seems to link some increased confidence to improved skills developed through the learning cycle provided by the Forum Theatre process. Improved

resilience appears to be linked to feeling more skilled with improved self-awareness about participants practice;

'I would say I am more confident in my skills or shall we say more aware, and through that awakening of self-awareness it allows you to be more self-critical in a good way'. P5, Mental Health Nurse, Post Registration, Female, 47.

The participant below seems to describe finding how they had carried a renewed sense of confidence around certain skills when participating in Forum Theatre, while also discovering they had skills in other areas, they didn't know they had. They indicate a renewed openness to learning and resilience to their internal critique. Furthermore, this could suggest some level of increased self-empathy;

'I realised I actually needed to improve so in some ways at the beginning of the day the things you think you are good at you realise you need to improve but you also learn things about yourself that you didn't think you were good at'. P2, Mental Health Nurse, Post Registration, Male, 28.

The resilience theme seems to have a thread of self-care running through it, which could be explained by the inclusivity and safety of the learning environment and through the active learning theme and process. For example, the ability to see others also struggle means participants empathise with these people, but are also more forgiving and accepting of themselves.

4.8.3 Subtheme: empathy

Empathy was identified as a subtheme of personal development because it appeared to be the outcome and was found at some level in all the themes, they all contributed to a sense of empathy in some way. In its simplest form, empathy is the ability to recognise emotions in others, and to understand other people's perspectives on a situation (Hojat, 2016). At its most developed, empathy can enable use of that insight to improve someone else's mood and to support them through challenging situations (King, 2011).

Empathy became a theme through the way participants expressed a sense that they were better able to empathise with others after taking part in Forum Theatre. They described new awareness and insight into recognising distress in patients and understanding their needs, therefore getting a better idea of what was required to help that person.

The process of Forum Theatre allowed them to see how communication can be interpreted in different ways, and how understanding the patient's perspective can guide an approach more centred around the needs of the patient. There was an understanding that very often consultations are driven by a clinician's own needs or that of the service rather than being person centred. This subtheme was considered both a practical skill and a phenomenon that can be drawn from the subjective experiences of participants;

'I learned to see the distress beneath the behaviour and that has helped me not to respond emotionally'. P3, Student Nurse, 3rd Year Pre-Registration Mental, Male, 35.

This comment seems to suggest insight into how it can be easy to respond to a patient due to their behaviours and perhaps mirror that behaviour or 'act out' ourselves emotionally. It seems by recognising the inner distress the participant was able to put the behaviour to one side. This was also observed by participants;

'I noticed how some people though, watching them with the patient, how easily they can become very defensive and realised that this doesn't always help the patient as it becomes about what we are worried about (nurses, ed.) rather than actually addressing the cues that the patient is giving you'. P6, Student Nurse, 3rd Year Pre-Registration Mental Health, Female, 26.

This comment shows that the participant has discovered how their own internal filters and fear of certain situations could become a barrier to effective communication, for example, viewing the patient as a problem because they are 'challenging' rather than empathising with their distress.

Building further on awareness of obstacles to empathising with patients is the following comment;

'I think being more empathic can improve your practice because you have learned to use your approach to suit the patient rather than kind of force the patient to adapt to you'. P7, Mental Health Nurse, Post Registration, Male, 39.

This comment appears to demonstrate a new awareness for the participant on how empathy is communicated to a patient by 'being with' rather than 'doing to' and taking a person centered approach.

The next comment illustrates how the importance of hearing the patient voice and how important assessment information isn't lost by taking time to empathise and connect with the person;

'To carry out assessment with awareness of their perspective and the way it's being conducted allows for them to be heard - I am able to shape it but they feel listened to and I don't miss important information'. P4, Mental Health Nurse, Post Registration, Female, 44.

Through empathising with the patient, participants felt able to strike better rapport and address the needs of the patient while also getting the information they needed as clinicians;

'It is okay to ask difficult questions and it is my own fears that have held me back from certain conversations in practice'. P5, Mental Health Nurse, Post Registration, Female, 47.

Furthermore, by empathising and building rapport this participant felt in a better position to ask difficult questions (likely about suicide);

'Understanding and having that relationship when there is trust allowed me to ask questions that I wouldn't ordinarily be comfortable asking the client, but it's showing you that you can ask it in a safe way'. P1, Mental Health Nurse, Post Registration, Male, 51.

This participant comments on how Forum Theatre helped him distinguish between empathy and sympathy and potential consequences of being overly sympathetic;

'In the training it was said that I am seeming to take on all the patients worries as my responsibility, I feel so sorry and try to make it okay for them and that wasn't what they wanted'. P2, Mental Health Nurse, Post Registration, Male, 28.

A sympathetic response to a patient could be viewed as an emotional response and has the potential to lead to professional boundaries being compromised resulting in entanglement issues. This comment appears to demonstrate new awareness to the patient's perspective, and how to adjust behaviour to be helpful to the needs of the patient over being driven by the nurse's own need to 'make it okay'.

The next comment appears very poignant to the empathy theme. It suggests that their experience in the Forum Theatre workshop was a reminder or a reconnection with the humanity of their role, and empathise with patients as people over a task or something to process;

'I suppose from a personal standpoint of emotions it's made me remember that these are people with real lives and they're not just a number or a referral'. *P4, Mental Health Nurse, Post Registration, Female, 44.*

The sense of connecting with the person rather than the process and understanding their experience, was highlighted very simply in this final comment that highlights empathic understanding:

'After attending this training, I think I also managed to become better at putting myself in the patient's shoes.' P8, Mental Health Nurse, Post Registration, Female, 35.

The emerging theme from participants who had undertaken the Forum Theatre workshop was an increased sense of empathy for the patients and understanding and of its application with the patients.

4.8.4 Empathy - a construct to be measured

This section provides further analysis on how the interview data, literature and researchers own experience were drawn upon and contributed to justifying the choice of the construct 'empathy' for the second phase of the research.

Through further reading and reflection on the analysis of the interviews the researcher started to think about what was at the centre of the themes, what was the glue that seemed to bind them together. It is important to remember that the design of the Forum Theatre workshop use within the study (Appendix 1) is focused upon supporting someone who is emotionally distressed. This means that the emphasis of the learning experience is placed on developing the skills to recognise the patient's emotions, concerns, and inner experience, then to explore these emotions, concerns, and experience, and to acknowledge them to generate a feeling in the patient of being understood.

The ability to become attuned to a patient's experience and to empathise, are key to continuous engagement and development of the therapeutic relationship (Chapter 1, section 1.4.3). The concept of attuning to a patient's needs is routed in empathy (Fields *et al*, 2011) and so quite organically the Forum Theatre Workshop at the centre of the current research will result in exploration and rehearsal of techniques related to recognition of empathy through feeling, understanding, and communicating.

The interviews may describe how development of empathy is a natural direction of travel and appears to be attributed and associated to the Forum Theatre workshop. The attributes to empathy they observed were helpful to the patient (actor) in the scenario and therefore positively reinforced by the SpectActors. Furthermore, the group of mental health nurses interviewed were perhaps a cohort more likely to be familiar with the skills required for provision of empathic care through their training and experience (Gerace, 2020). However, there may previously have been little opportunity to consider the critical application of these skills in depth and rehearse them in the way studied in the current research. Conversely, they may also be expressing fatigue and burn out, and therefore less able to provide empathic care, and the current research may have partially addressed this (Bell, Hopkin and Forrester, 2019).

If it is meaningful empathic connection, understanding and communication that works for the patient (Richardson, Percy and Hughes, 2015) then the Forum Theatre workshop would have naturally gravitated towards that outcome until the concept and skill is actualised, at least for that point in time. Therefore, it could be argued that each theme that has been drawn from the data has a role to play in relation to empathy development in some capacity as indicated on the thematic map (Figure 5). Analysis of further quotes provide some indication of how empathy threads its way through each of the four themes and subthemes.

In this quote the participant appears be highlighting how the 'authenticity' of the acting elicited '*empathy'* for the characters in the play;

'The actors just responded very naturally it wasn't like say you might see in a film or a play, it wasn't overdone it was very subtle and so yes, I guess they had scripts, but I could empathise with the emotions as they were actual emotions in response to the nurse' P5, Mental Health Nurse, Post Registration, Female, 47.

In this quote the participant indicates that the 'learning environment' modelled the safety to be able to be open without feeling fearful through the 'empathic approach' of the facilitator;

'In a way the facilitator was creating with us the same kind of space that we needed to create for the actor, care and empathy, so that it is safe to share feelings'. P3, Student Nurse, 3rd Year Pre-Registration Mental, Male, 35.

In this quote the participant appears to reflect upon how the 'active learning' process in the use of reflection and rehearsal helps to develop skills in *'*empathising*'* with a patient. This included how actors would tailor responses in light of what was needed for those people in the group;

'*It was much more like a live reflection session, we spent time practicing how to empathise and help the patient. The actors seemed to tailor their responses to help us work on those areas that we needed to improve'.* P8, Mental Health Nurse, Post Registration, Female, 35.

The 'Personal development' theme highlighted three outcomes of Forum Theatre in the context of the current research which were communication skills, resilience and empathy as illustrated in the thematic map (Figure 5). The two quotes below further demonstrate how communications skills and resilience supported empathy as the overall measurable outcome to emerge from the interview data;

This comment suggests that the awareness was raised on how disconnected from the person one can appear when asking questions and how that can be perceived by the patient as a lack of empathy when communicating;

'Yeah, it's made me more aware of how 'robotic' you can come across when you're asking questions, and how it affects the discussion and if that's how you feel then the client is absolutely going to get that sense from you that you lack empathy and are just asking them the question because you have to'. P1, Mental Health Nurse, Post Registration, Male, 51.

This quote appears to demonstrate how for this participant they have felt more resilient through being able to empathise with the patient. It indicates that because they can understand the patient perspective, they are more confident in the interaction;

'I think it really has helped, I think I feel more confident in what I am doing as I am less phased by the behaviour of patients. I think it has changed it for the better because I am more able to empathise with patients'. P6, Student Nurse, 3rd Year Pre-Registration Mental Health, Female, 26.

Through further exploration and analysis of the interview data the researcher felt more assured that empathy was the construct of interest for phase two of the project, however, it was important to take some time to reflect upon these finding further and consider the researchers own experiences and relationship with Forum Theatre. It was also crucial to hear the thoughts and feelings from the participants who had kindly agreed to take part in the research on the findings and consider what the literature indicated.

4.8.5 Reflecting on the emergence of empathy

The process of analysing the interviews data led to further reflection by the researcher on his own experience as a participant and in the delivery of Forum Theatre. It was important that these thoughts were explored and acknowledged within the emergence of the empathy theme.

The researcher didn't enter this project with any major conscious assumption of empathy being at the centre. There was probably an awareness that empathy is an essential factor alongside others in delivering care. The process of the current research led to this discovery and illuminated empathy as the construct for measure in phase two.

As a mental health nurse, educator and advocate for patients, families, and carers the drive to deliver high standards of care for people with mental health conditions is crucial. What we know from service users is the most important aspect of their care is for mental health nurses to listen and try to understand their experience so that we can help them (Chapter 1, section 1.4.1). This really does highlight the importance of empathy and the importance of developing scenarios that are based on real life scenarios for Forum Theatre workshops. The scenarios used in the researcher work commonly draw upon positive feedback, for example when interventions have gone well, but also complaints, and sadly. from serious incidents that often involve the loss of life by suicide.

The learning from investigations from incidents such as suicide will often highlight the importance for patients and families of 'feeling listened to', that the clinician genuinely cares, is trying to understand and wants to help (Chapter 1, section 1.4.5). This is important because it is the bedrock for which the Forum Theatre sessions used in the current research are built upon, people in emotional crisis who need to feel heard.

The researchers own experience from his involvement in Forum Theatre is that it serves to empower those who take part, it was pro-social by design in that it promoted empathy for the individual and the community of learners within the forum to bring about positive change. The researcher knows from experience how undertaking a Forum Theatre workshop can potentially feel very uncomfortable due to a sense of feeling exposed and at the scrutiny of others. This was especially true for the researcher when taking the stage as a SpectActor to interact with the actor. However, it was the empathy from those around and how they would try to understand where the challenges were and their attempts to help that created what might be described as synergy in the group.

When considering the other themes in relation to the researchers own experience of Forum Theatre it is difficult not to concur with analysis of the interviews. The researcher cannot deny that there is potential for his own unconscious influence on what was interpreted because of the level of involvement he has in Forum Theatre in practice. It is important to be aware of this, not just to try to remain objective but also to consider his own subjective experiences and contrast these with the findings.

Ultimately, the aim of a professional doctorate is to research with view to improving practice and so it was important not to remove his own experiences completely from the process. On balance, the researchers own experiences of Forum Theatre correlated with the analysis of the interviews of the current research, indicating that empathy needed to be measured in phase two to establish whether it can be confirmed as an outcome that can be generalised in a bigger sample.

4.9 Participant Focus Group

Before moving into deeper analysis of the findings it felt timely to arrange a focus group to share the findings with the participants who had kindly provided interviews, and provide an opportunity for them to exchange their thoughts on the interpretation. A short presentation (Appendix 10) was delivered over Microsoft Teams (due to the Covid-19 pandemic restrictions) with explanation of the themes, interpretation of the results and some narrative about the journey to date.

The group agreed with the interpretation that empathy was at the centre of their Forum Theatre experience and felt it made a lot of sense based on the presentation and their own experiences. The group affirmed the importance of the other themes and how they interrelate and build on one another. They identified with the authenticity theme and discussed how it was important to the integrity of Forum Theatre. They described leaving the session with warm feelings and believed that this was linked to the authenticity and learning environment themes.

The group also described respecting the effort that had been put into arranging Forum Theatre sessions and how it made them feel valued. They felt the intensity, uniqueness of Forum Theatre and the connections they made in the room with each other led to a good feeling and made the sessions memorable.

I asked the group about their own journey since the interviews and although individuals interviewed had not met together before, two of them were now involved in supporting the delivery of Forum Theatre based sessions in suicide prevention training offered in the Trust. The training has become popular with all staff working in frontline mental health services who

are expected to attend every two years. These two participants had identified when using Forum Theatre techniques that most of the time the issues they encountered were when staff struggled to understand the patient's perspective. They were able to use Forum theatre techniques with the staff to offer better communication skills and build rapport.

Other participants felt that Forum Theatre had been an experience that had stayed with them and believed that Forum Theatre should be used in more training in the Trust. They encourage student nurses on placement to attend when possible and described how it should be part of mental health nurse training.

It was good to have the opportunity to share the results with the interview participants and get their perspectives. It was encouraging to hear that it had been memorable and about their own progress since taking part. I agreed to share the overall outcomes of the study with the group once completed.

4.10 Preparing for phase two

There has been a lot of debate in the literature about the construct of empathy (Hogan, 1969; Hojat *et al*, 2015; King, 2011; Stansfield *et al*, 2016). It has been described as an ability to understand the experiences of others, often referred to as cognitive empathy (Hojat, 2016). It has also been described as an emotion which features the sharing of feelings often referred to as emotional or affective empathy (King, 2011). Furthermore, it has been understood as a concept that involves both cognitive (understanding) and emotional (Feeling) attributes (Stansfield *et al*, 2016).

It is important to consider the differences between cognitive and emotional empathy because of the implications for patient care (Hojat, 2016) and which learning processes might lead to empathy development from a learning and teaching perspective. The researcher was mindful that some further thought and reflection on the results at this stage was important for informing the choice of measure for phase two.

While there have been a number of empathy scales developed it was important to find a scale that focused on healthcare professionals, many of the scales used in the past were designed for the general public (Yu and Kirk, 2009). Furthermore, it was important that the scale was designed to measure the construct of empathy that correlated with the findings in phase one, that empathy is related to communicating feeling and understanding to others, which resulted in the choice of the Jefferson Scale of Empathy explored further (Chapter 3, section 3.6.3).

4.11 Phase 2 Quantitative Data Analysis and Results

The qualitative findings suggested that Forum Theatre promoted an increased sense of empathy for patients and the skills to use empathy to help them. This led to the development of the phase 2 research question; 'Is there a significant difference in sense of empathy for others before and after engaging in Forum Theatre?' The impact of Forum Theatre on participant empathy was measured for phase 2 of the study using the Jefferson Scale of Empathy pre and post Forum Theatre intervention. Permission was sought and given from Jefferson University to use the scale (Appendix 8). The analysis involved using SPPSv27 to analyse frequency and descriptive statistics of the data set before selection of the appropriate tests to analyse normality of distributions, compare means, control for confounding variables, test for homogeneity of variance and analyse for variance when comparing means on pre-post empathy scores.

4.11.1 Participants

Phase 2 participants were pre and post registration mental health nursing students attending a workshop (Appendix 1) using Forum Theatre techniques. There were 153 participants (from the 162 sample) with usable data (correctly completed questionnaires) for the final statistical analysis. Participant information was provided, and written consent was sought from each participant before the start of the session. Table 14 outlines the gender, age ranges, total numbers and numbers per workshop included for analysis for the phase 2 participants.

Table 14: Phase 2 participants

Phase 2 Participants												
Gender	Female				Male				Total			
Total Number Completed	115				47				162			
Percentage	72%				28%				100%			
Age 21 - 30	36				11				47			
Age 31 - 40	39				15				54			
Age 41 - 50	32				14				46			
Age 51 - 60	7				8				15			
Per Workshop included for analysis n=153	1	2	3	4	5	6	7	8	9	10	11	12
Male	3	5	5	1	3	4	5	3	4	4	4	2
Female	9	8	7	11	12	11	7	10	10	7	8	10
Age 21 - 30	4	6	2	3	5	3	6	5	3	3	3	3
Age 31 - 40	4	3	5	2	3	5	4	4	5	5	4	5
Age 41 - 50	2	2	3	6	6	5	1	2	4	3	5	4
Age 51 - 60	2	1	2	1	1	2	1	2	2	0	0	0

Total per workshop	12	14	12	12	15	15	12	13	14	12	12	12
• n=162 completed the Jefferson Scale of Empathy • n=9 Jefferson Scales of Empathy were incomplete and unsatisfactory for analysis • n=153 Jefferson Scales of Empathy were satisfactory for analysis												

4.11.2 Measure

The Jefferson Scale of Empathy is a 20-item instrument specifically developed to measure empathy in the context of health professions education and patient care for administration to health professions students and practitioners (Hojat, 2016). Items are answered on a 7-point Likert-type scale (1 = Strongly Disagree, 7 = Strongly Agree). Half of the items are positively worded and directly scored, and the other half are negatively worded (reverse scored). The range of possible scores runs from 20 to 140 points. Higher scores are associated with a greater degree of empathy (Hojat, 2016).

Hojat and Gonnella, (2015) and Hojat *et al*, (2018) provide typical descriptive statistics and score distributions for the Jefferson Scale of Empathy. Normative score distributions of the Jefferson Scale of Empathy tended to be moderately skewed and platykurtic and women obtain a significantly higher mean score (116.2 ± 9.7) than men (112.3 ± 10.8) on the Jefferson Empathy Scale ($t_{2,635} = 9.9$, $p < 0.01$). The tentative cut-off score to identify low scorers was ≤95 for men and ≤100 for women. This data was used for comparison with the results of the current research study.

The Jefferson Scale of Empathy was administered in paper form before and after a four-hour Forum Theatre workshop (Appendix 1) focused on supporting a patient played by an actor who

was experiencing a mental health crisis. This was the same scenario as used in phase 1 but delivered in twelve separate workshops over a three-month period to reach a greater number of participants that used the same two actors and Joker as phase 1 for consistency (Chapter 3, section 3.5.4).

4.11.3 Frequency analysis

The number of the female respondents (n = 110, 71.9%) was much higher than the number of male respondents (n = 43, 28.1%). Figure 7 shows the comparative difference between the number of male and female respondents. Figure 8 demonstrates the spread of age range across the sample. A lower number of the respondents belonged to the age range of 51 – 60 (n = 14, 9.2%). Comparatively, nearly an equal portion of respondents (28% – 32%) belonged to the age range of 21 – 30, 31 – 40, 41 – 50 respectively.

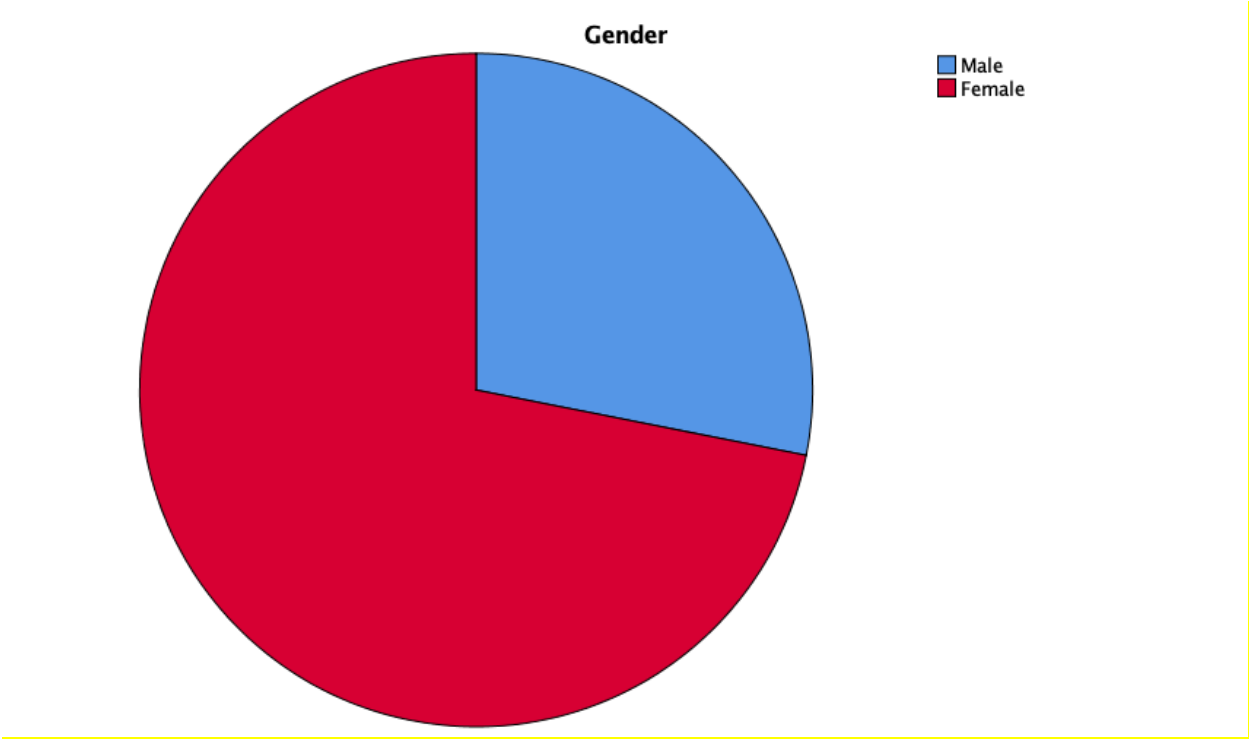

Figure 7: Gender distribution

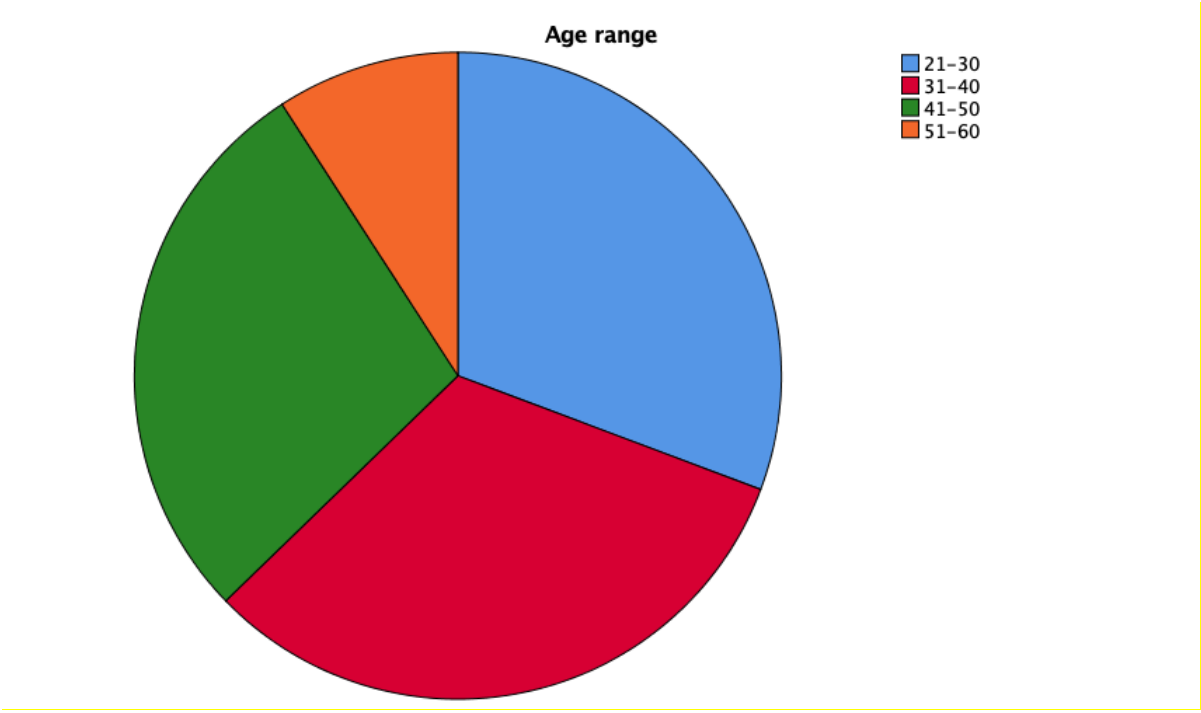

Figure 8: Age range distribution

4.11.4 Descriptive analysis

The mean pre–Forum Theatre empathy score was 114.29, with a standard deviation of 12.57, indicating that the score was more dispersed. Additionally, the mean post-Forum Theatre empathy score was 121.63, with a standard deviation of 10.20, showing a larger dispersion in that score. Both pre and post Forum Theatre empathy ratings were right skewed distributed as demonstrated in the graphs Figure 9 and Figure 10, meaning that a larger percentage of total respondents have a pre-empathy score between 100 and 130, and a higher percentage of total respondents have a post empathy score between 120 and 130.

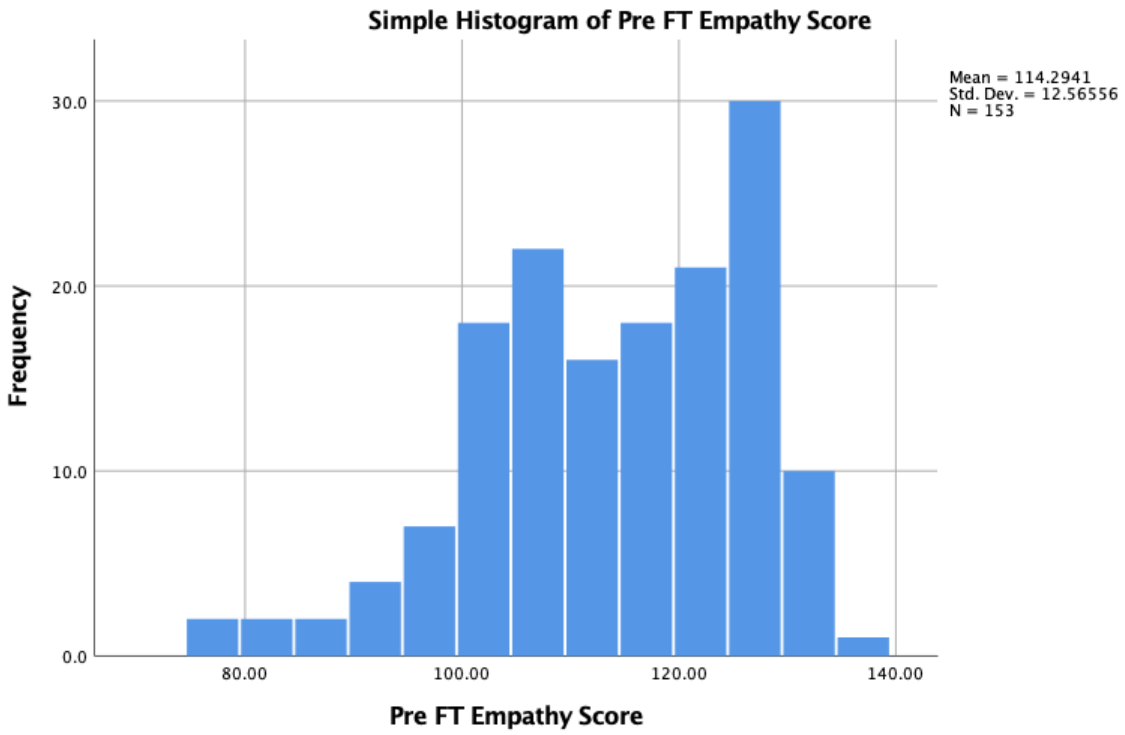

Figure 9: Histogram of pre-Forum Theatre empathy scores

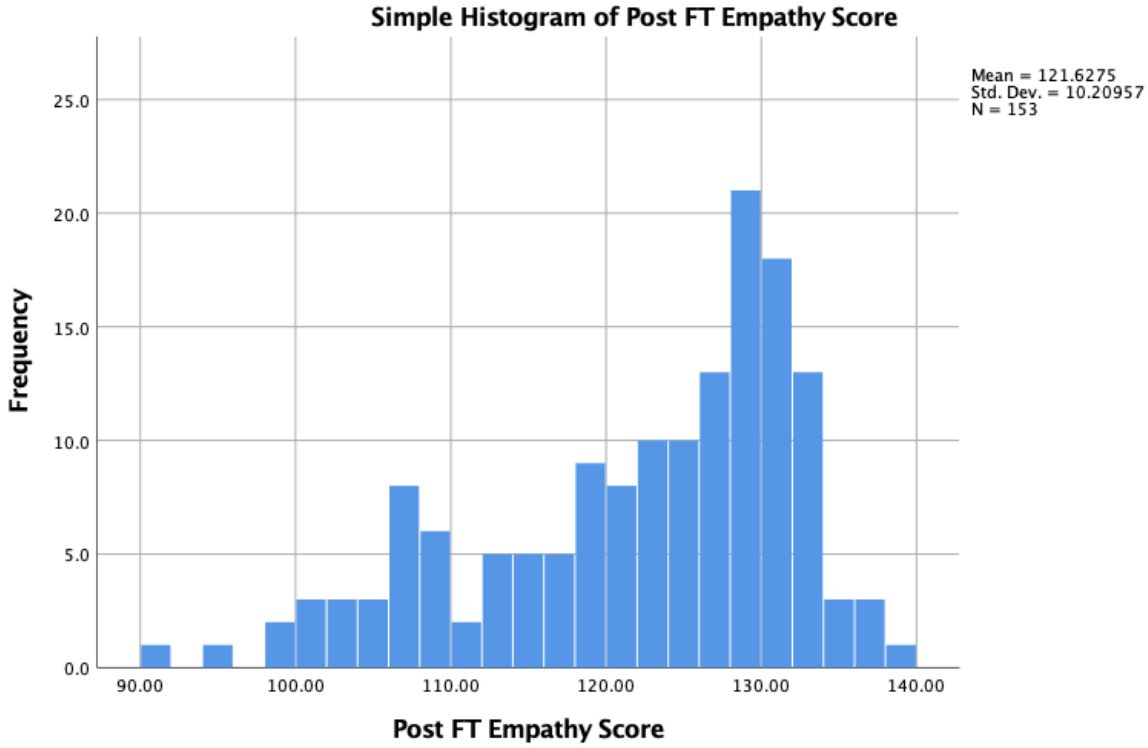

Figure 10: Histogram of post-Forum Theatre empathy scores

4.11.5 Normality of distribution

The distribution of scores was visually right skewed on the histograms (Figure 9 and Figure 10), therefore it was important to test the assumption of normality for the suitability of using a parametric test to compare pre and post empathy mean scores (Field, 2018). The distribution of the pre and post empathy scores was confirmed as abnormal as per the p value (p value < 0.05) on the Shapiro-Wilk test. When comparing the distributions to the normative score distributions there is a tendency for the Jefferson Scale of Empathy to be moderately skewed and platykurtic. While the pre-post empathy scores of the current study were abnormally skewed to the right, the normative distributions for the scores remain within the normal range (Hojat and Gonnella, 2015). Cut off values for low scorers are suggested as ≤95 for males and ≤100 for females and so there did seem to be several outliers that could have affected the score distributions.

4.11.6 Rationale for choice of tests

The Shapiro-Wilk test for normality of distribution was used because the assumption for a matched paired t-test to compare means is that the data set is normally distributed. The Shapiro-Wilk test indicated that the pre and post empathy scores (Figure 9 and Figure 10 respectively) were not normally distributed and therefore use of a parametric test was ruled out. The analysis therefore required non-parametric equivalent statistical testing to establish whether there were any significant differences in the empathy score between pre and post Forum Theatre and whether gender had any significant effect on the relationship between the pre and post-empathy scores.

To test for significant difference, the non-parametric Wilcoxon signed-rank test was conducted. The Wilcoxon signed-rank test is a non-parametric statistical hypothesis test that can be used to determine the location of a group of samples, or to compare the locations of two populations using matched samples (Field, 2018). To test the significant effect on the correlation between gender on pre and post empathy scores, the non-parametric partial correlation test using SPSS (v27) syntax was conducted.

4.11.7 Wilcoxon signed-rank test

A Wilcoxon signed-rank test (non-parametric t-test) with an α of .05 was used to compare the empathy scores measured before (M=114.29, SD=12.57) and after (M=121.63, SD=10.21) Forum Theatre. The Wilcoxon signed-rank test revealed that on average, empathy scores in the post-test were 7.34 points higher than the pre-test scores (Figure 11). The difference was statistically significant, $z = -8.199$, $p<.001$. To test the effect of gender as a potential confound on pre and post empathy scores the non- parametric partial correlation test was run.

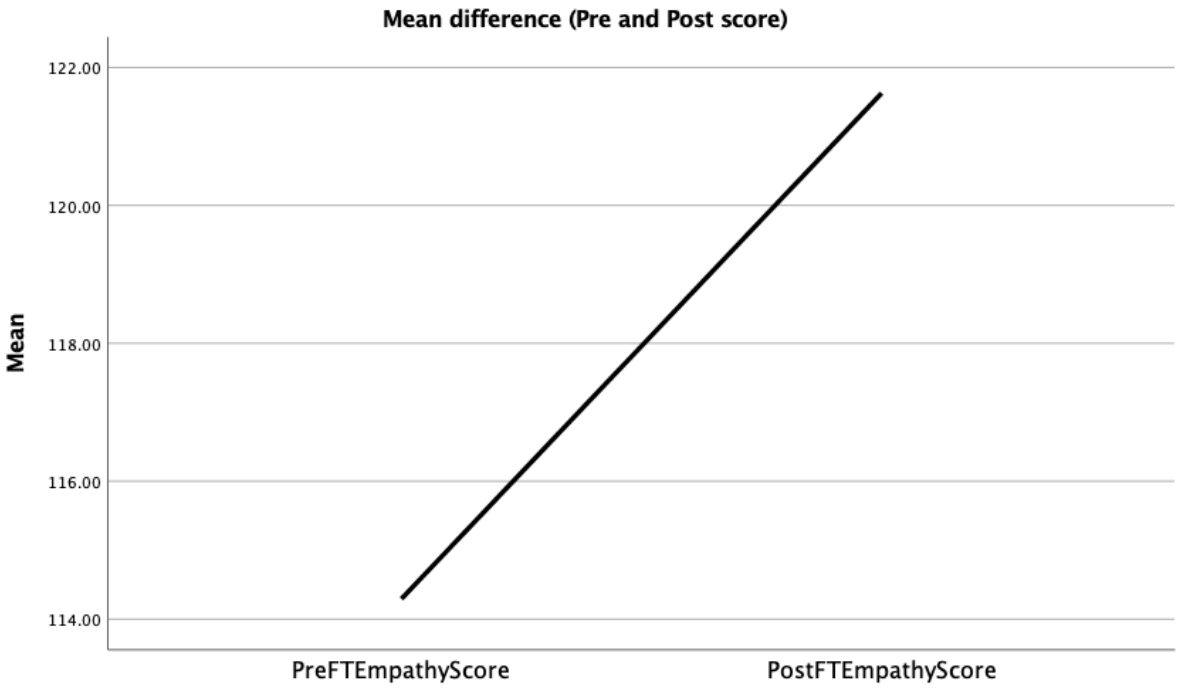

Figure 11: Mean difference between pre and post empathy scores

Partial correlation - controlling for gender

The non-parametric partial correlation test was used to explore the relationship between pre- and post-empathy score, while controlling the scores for gender. There was a strong, positive, partial correlation between pre and post empathy scores when controlling for gender, r = .619, n = 153, p<.001 (Figure 12). The analysis therefore confirmed that gender was a confound controlling the correlation between pre and post empathy scores.

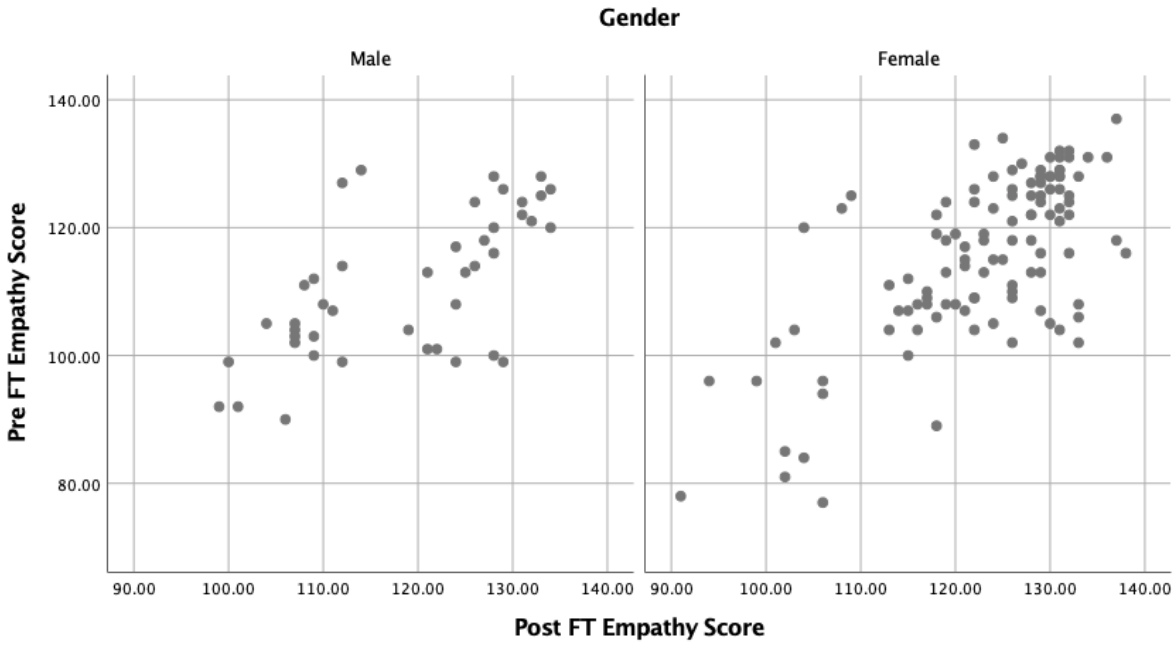

Figure 12: Pre and post empathy scores by gender

Levene's test of homogeneity of variance for gender

Given the finding that gender was confounding the results, it was important to explore the significance on the overall results through analysis of variance. Before this could happen the assumption of homogeneity of variance needed to be tested. Levene's test is used to test the assumption of equal variances to inform whether a parametric test can be used to analyse variance (Field, 2018).

Based on both mean and median values for gender as a control variable, the homogeneity of variance test indicated that the assumption was met for the pre-empathy scores, with a p value > 0.05. However, the homogeneity of variance assumption was not met for the post-empathy scores, with a p value > 0.05 for both mean and median values when gender was used as a control variable.

Because one of the key variables failed to pass the assumption for homogeneity of variance, parametric testing for analysis of variance such as using One-Way ANOVA would not draw reliable conclusions. The use of a comparable non-parametric test was therefore required and as a result, the Kruskal-Wallis H test was used for analysis of variance (Field, 2018).

Kruskal-Wallis H test – analysis of variance of gender

The non-parametric Kruskal-Wallis H test with an α of .05 was used to compare the mean empathy scores measured between male and females. The test revealed that on average, empathy scores of females in both tests were approximately 5 points higher than that of male with a 95% confidence level. The difference was statistically significant, $p<.001$, two-tailed. The graph (Figure 13) shows that how the likelihood of a good average empathy score was higher for the females than males but there is a linear improvement in empathy scores for both genders before and after Forum Theatre. These results are comparable to the proxy normative scores for the Jefferson Empathy Scale, where females score approximately 4 points higher than males on average (Hojat and Gonnella, 2015).

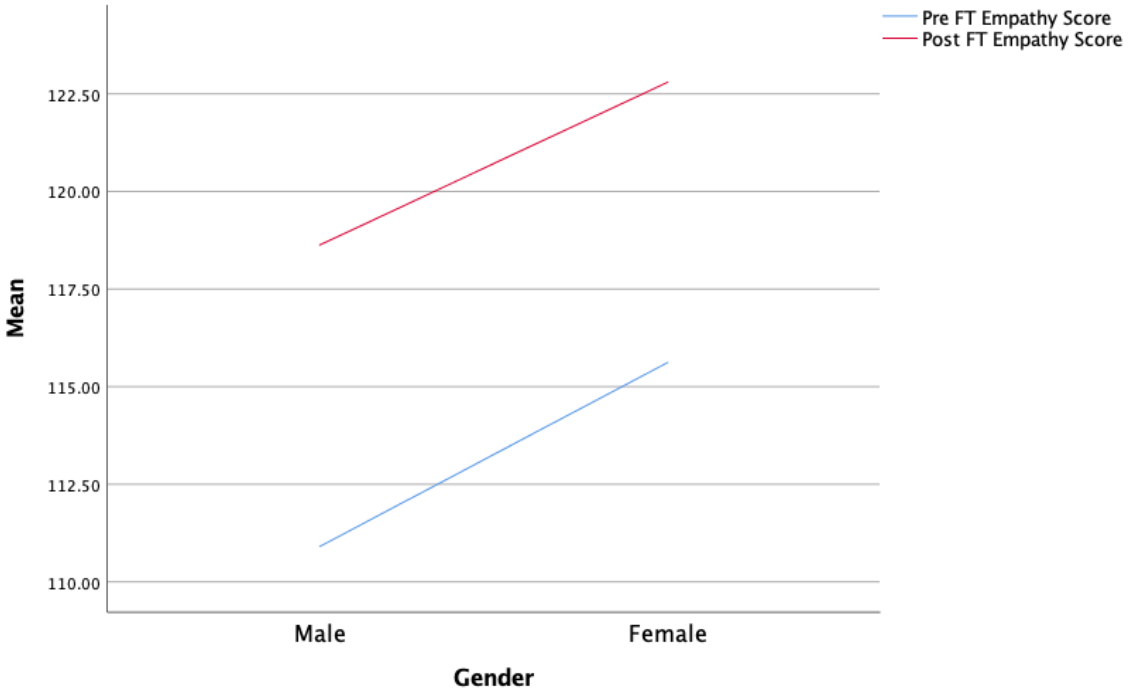

Figure 13: Mean difference between male and female

4.11.8 Answering the phase 2 research question

The results demonstrate that there is a significant difference between genders in perceived empathy on the Jefferson Empathy Scale, with females scoring higher than males pre and post Forum Theatre intervention which concurs with the proxy normative scores for the scale. While females score higher pre and post Forum Theatre, there remains a statistically significant increase in empathy score for both males and females post Forum Theatre when adjusting for covariance due to gender. Therefore, it can be concluded that there is an increased sense of empathy for others after taking part in Forum Theatre for both males and females. This answers the phase 2 research questions 'Is there a significant difference in sense of empathy for others before and after engaging in Forum Theatre?'

4.12 Mixed Methods Interpretation

4.12.1 Integration

The integration of the methods is inherent in the QUAL-quant sequential research design used in this study because the phase 2 question and choice of the Jefferson Scale of Empathy to measure empathy were developed and used based on the emergent data from phase 1. The results from the first phase of the research were used to connect and build the second stage of the research design. Meta-inference indicated whether the follow-up quantitative phase could build on the qualitative themes to provide a transferable understanding of the research questions, (Tashakkori and Teddlie, 2010).

Integration at the reporting and interpretation level of this design was to provide a simple visualisation of the confirmed increased sense of empathy. The thesis discussion (Chapter 5) was then used to further integrate the mixed methods results through the narrative (Moseholm and Fetters, 2017). The statistical data from phase 2 confirms and builds on the phase 1 results through demonstrating significant transferability of increased empathy in participants who have undertaken a Forum Theatre training session.

4.12.2 Joint display analysis

The joint display (Table 15) allowed key examples from the phase 1 and phase 2 data strands to be brought together visually. Drawing on Fetter's (2019) steps on the iterative process of joint display analysis, themes, patterns, and anomalies were identified in the results based on the findings of both data sets. It should be noted that this procedure was not necessary for a sequential exploratory design and is more often seen used in concurrent or triangulation mixed methods analysis where the data has not yet been connected in any way. However, the researcher felt that the joint display was warranted as a user-friendly way of visualising the mixed methods results.

The process of building and rejecting multiple iterations of the joint display did provide an opportunity to compare quantitative and qualitative data to arrive at an optimized understanding of the mixed findings. Finally, it provided an opportunity to take notes that would inform the discussion. The themes identified on the final joint display were those that explicitly highlighted the empathy phenomena. The quantitative data used were the results of a paired samples Wilcoxon test and Kruskal-Wallis test confirming increased empathy in participants who had undertook the Forum Theatre workshop.

4.12.3 The joint display

The joint display (Table 15) demonstrates how the phase 1 interview data and emergent themes were used to inform the phase 2 research question, choice of measure to test whether the central phenomena of increased empathy was transferrable to a larger sample of mental health nurses. Sample quotes from the qualitative interviews were compared to results from the statistical analyses of the survey data, and connected to answer the mixed methods research question; 'What conclusions can be drawn from the analysis about the application of forum techniques?'. The answer to that question is that Forum Theatre can increase understanding of empathy for others for mental health nurses in a simulated secnario and is discussed in depth in chapter 5.

Table 15: Joint display to illustrate the mixed methods results

Joint Display					
Research Questions	How is Forum Theatre subjectively experienced?	What specific skill sets are addressed by Forum Theatre techniques?	Is there a significant difference in sense of empathy for others before and after engaging in Forum Theatre?	What conclusions can be drawn from the analysis about the application of Forum Theatre techniques?	

Data Analysis and Results	**Themes and subthemes**
	- Learning Environment
	- Authenticity
	- Active Learning
	- Personal Development
	  - Communication skills
	  - Confidence
	  - Empathy
	
	Example:
	'The actors were very skilled in how they improvised and went with the scenario they altered their responses depending on how we were with them which was what I thought was very clever and innovative'. P8, Mental Health Nurse, Post Registration, Female, 35.
		Empathy = centre of Forum Theatre experience and to be tested in phase 2
		
		Example:
		'I learned to see the distress beneath the behaviour and that has helped me not to respond emotionally'. P3, Student Nurse, 3rd Year Pre-Registration Mental, Male, 35.
		
		Identified need for empathy measure (JSE) for phase 2
			Results of paired T-Test
			
			Significant increase in the empathy score of mental health nurses (N=153) who had undertaken a Forum Theatre session (M=121.62, SD=10.20) than before taking part in a Forum Theatre session (M=114.29, SD=12.56); *t* (152)= -9.70, p = < .001
				Forum Theatre can increase understanding of empathy for others in mental health nurses.	**Research Aim**
					To understand the effectiveness of Forum Theatre techniques on mental health nursing skills.

Sequence and triangulation	**Phase 1 = Qual**	**Phase 1 = Qual**	**Phase 2 = Quant**	**Method = Mixed**	**Discussion**

4.13 Summary

This chapter provided an account of the how the analysis was conducted for phase 1 and 2 of the research and presentation of the results. The qualitative phase 1 objective was to explore the individual experience of mental health nurses who undertake training that employs Forum Theatre techniques and to analyse the experience in relation to specific skill sets. Data was collected through semi-structured interviews with eight mental health nursing students who had undertaken a Forum Theatre workshop.

The interviews were thematically analysed using Braun and Clarke's (2006) six steps to answer the research questions: 'How is Forum Theatre experienced?' and 'What specific skillsets are addressed by Forum Theatre techniques?' The phase 1 findings revealed that Forum Theatre increased empathy in participants, supported by four themes: 'Learning environment,' 'Authenticity,' 'Active Learning,' and 'Personal Development' with subthemes 'communication,' 'resilience' and 'empathy.'

The Quantitative phase 2 objective was to examine the impact of the application of skills acquired during a simulated practice scenario. The results of phase 1 were used to inform the selection of the Jefferson Scale of Empathy to measure pre-post Forum Theatre intervention empathy scores to answer the research question: 'Is there a significant difference in sense of empathy for others before and after engaging in Forum Theatre?' A non-parametric comparison testing of mean scores on the Jefferson Empathy of Scale confirmed a significant increase in empathy for males and female participants post Forum Theatre, confirming that Forum Theatre techniques increased participant empathy for others.

4.14 Field Notes

(Researcher field notes, June 2019)

Doing the interviews has been a humbling experience; it was amazing just how much participants cared about their practice and continuous improvement. I think for clinicians who are working with suicide, it creates another level of motivation to do whatever they can to make a difference in prevention because they see the tragic aftermath for the bereaved.

The interviews naturally challenged some of my assumptions and really brought to light areas I had not considered, offering deeper insights into how Forum Theatre is experienced. For example, I would never have guessed that empathy would have been at the centre of the experience and authenticity, the glue that binds and makes it memorable.

However, I am the one who has interpreted the results, and despite trying to bracket my assumptions during analysis, I cannot help but wonder whether someone else might draw out a different focus. I think it will be imperative to the validity and ethics of the research that I share my interpretations with interviewees to get their actual point of view on whether they connect with them. It would be great to get their feedback and, if necessary, review the analysis.

I do feel a little happier now that I have taken a mixed-methods approach, as the next phase will help provide more objective confirmation of the findings. However, I wonder whether the empathy scores might reduce post-Forum Theatre because some deconstructing can go on in a session for many people. For example, would it be a fair assumption to say that most nurses, and healthcare professionals, for that matter, are likely to believe they are highly empathic - why would they enter the profession if not? In Forum Theatre, they may learn that they are not necessarily displaying empathy even if they feel it, which could be for unconscious reasons through lack of awareness. I am also mindful that it would be of ethical concern if a Forum Theatre session deconstructed people and left them like that without follow-up.

Final thought of day:
Where would we all be without empathy... I begin to question whether this is just obvious, plain old common sense. 'It was always about empathy, stupid!'

Chapter 5 Discussion of Findings

5.1 Introduction

The discussion provides a deeper look into the meaning, importance, and relevance of the findings. The focus is to explain and evaluate the findings and demonstrate how they relate to the literature and research questions to make an argument in support of the overall conclusion. The discussion begins by providing a model built through synthesis of the findings that illustrates how Forum Theatre can be used to develop empathy in mental health nurses. The themes, their patterns, principles, and relationships that contribute to each stage of empathy development illustrated in the model is then discussed in light of meaning within the literature and relationship to the research questions.

5.2 Recapitulation Research Aim and Findings

The research aim was to understand the effectiveness of Forum Theatre techniques on mental health nursing skills. To achieve the aim a two-phase sequential exploratory mixed methods research design was developed (Chapter 3, section 3.4) to answer how Forum Theatre is subjectively experienced and what specific skill sets are addressed.

The findings suggested that Forum Theatre led to increased empathy supported by four themes (Chapter 4, section 4.2). The themes included Personal Development in communicating, resilience and increased empathy. Personal Development was supported by the learning

environment, the active learning process and authenticity related to practice scenarios, realistic acting and emotional exchanges.

The Jefferson Empathy Scale, (Hojat *et al*, 2004) was used to measure empathy pre and post Forum Theatre intervention (Chapter 3, section 3.5.22). A paired samples Wilcoxon test and Kruskal-Wallis test (Chapter 4, section 4.11.9) confirmed a significant increase in empathy in 95% of cases, providing confirmation that Forum Theatre techniques can increase sense of empathy for others in mental health nurses.

5.3 Forum Theatre and Empathy Development Cycle

Figure 14 illustrates how the four themes Authenticity, Learning Environment, Active Learning and Personal Development relate to each other and feed into affective, cognitive, and behavioural domains of empathy in Forum Theatre. The red, amber, and green symbolise the need to stop and think before acting to comprehend the affective domain and understand the patient's perspective before a person can communicate empathy in a helpful way.

The model was developed through the synthesis of the results, building on the concept introduced in the thematic map (Chapter 4, section 4.3) on how the themes inform each other and through the natural discourse of critical thinking, reflection, and writing. The model draws upon King's structure that refers to three domains of empathy that include; affect sharing, cognitive understanding of others and behaviour which relates to communicating empathy to others within the therapeutic relationship (King, 2011). The results from the study suggest that the Forum Theatre techniques used within the workshop may contribute to a perceived sense

of empathy and the model illustrates how each stage of the Forum Theatre process in the workshop could contribute to the structure of empathy provided by King.

The discussion had originally built to a presentation of the model towards the end of the chapter, however, the researcher felt it would provide more context to the reader and the discussion with the model given at the beginning. Therefore, deeper explanation of each of the themes and their role in answering the research questions and development of empathy, contribute to the model and are discussed throughout the rest of the chapter, and King is discussed in more depth in section 5.7.3.

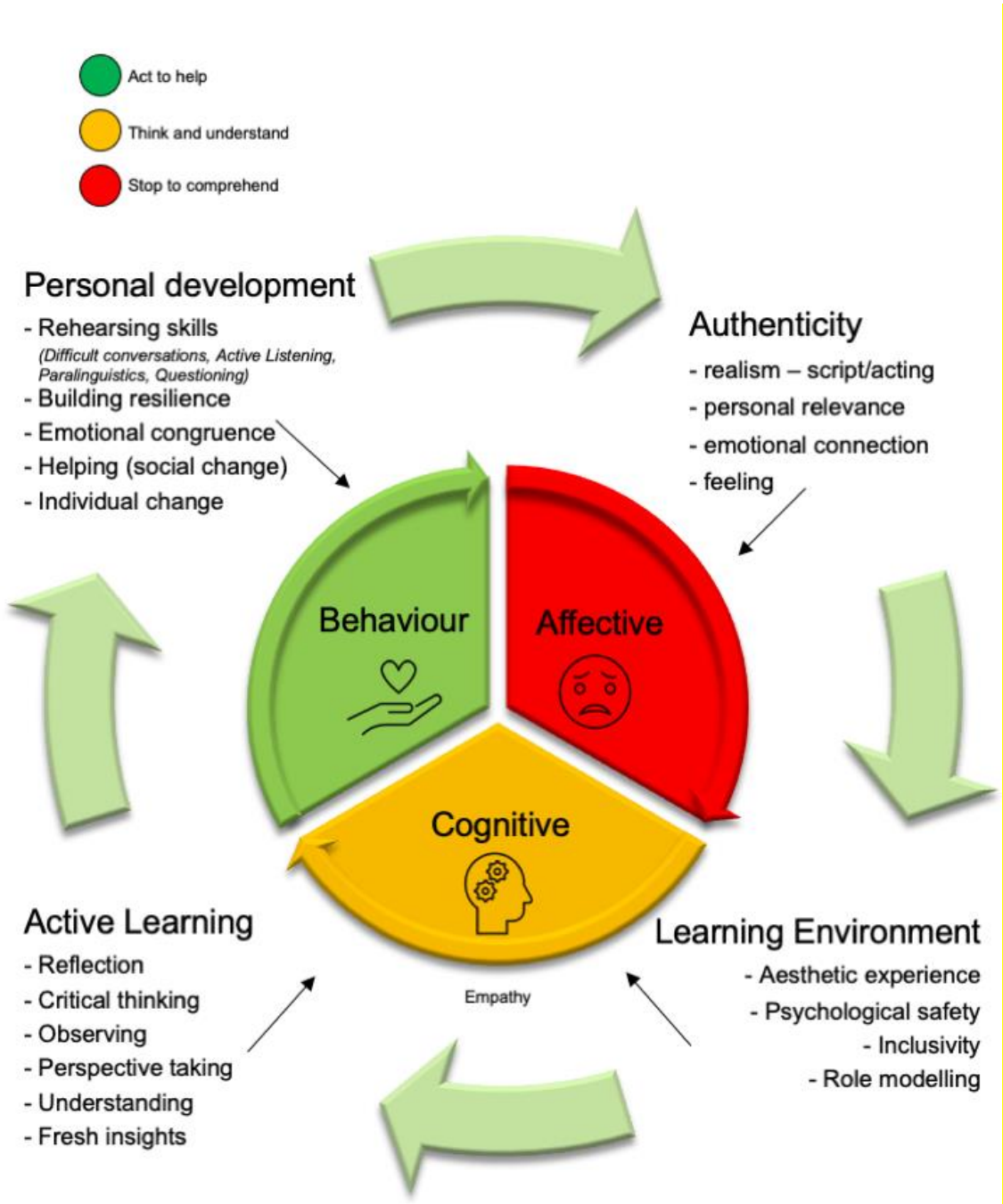

Figure 14: Empathy development in the Forum Theatre workshop

5.4 The Learning Environment (subjective experience)

5.4.1 Psychological safety

The findings indicated that the Forum Theatre workshop for supporting someone in mental health crisis provided a safe environment to rehearse interventions without fear and risk of doing harm to a real patient (Chapter 4, section 4.5). These findings are consistent with Wasyiko and Stickely, (2003) who suggested Forum Theatre provides an opportunity to rehearse practice scenarios safely in a low-risk environment. This finding was also supported by D'Ardis, (2014) and Wilson, (2013) who found that Forum Theatre provides a safe environment to rehearse skills without causing emotional harm to patients. This finding builds on the concept of safe learning by providing insights into how Forum Theatre provided a safe space specifically for mental health nurses to explore patient safety in relation to suicide with reduced fear.

The clearest explanation for this finding is the use of an actor in a simulated scenario to relieve fears of doing harm to a real patient. However, there could be other factors that underpin sense of safety in the learning environment. Fear of doing harm can be an emotional burden and barrier to learning (Edmondson, 2018). Those who enter healthcare professions are generally motivated by a desire to support others and intrinsically want to avoid harm, so there is a natural internal fear (Awenat *et al*, 2017; Baile and Walters, 2013). This internal fear can be compounded by external sources too, fear of blame for a patient death and potential repercussions remains a challenge within the NHS (Wise, 2018; Glasper, 2016).

The power of interacting as a SpectActor may partly be explained through a theatre concept known as 'breaking the fourth wall' which didn't allow an audience to sit passively and get lost in a show (Brecht, 2014). Traditionally the fourth wall was an invisible screen between actor and the audience, and it was thought that breaking that would remind the audience that they were watching a play and lose its realism (Preston, 2016).

In Forum Theatre the fourth wall is frequently broken by the Joker and SpectActors, enhancing immersion in the experience. This democratises the theatre, breaking down hierarchy promoting strength in the community of learners (Wilkinson, 2015). Breaking the fourth wall and interacting with an actor mitigated against actual harm to anyone and provided freedom to practice interventions safely.

5.4.2 Role modelling and inclusivity

The current research highlighted the role the Joker played in creating an inclusive environment whereby participants felt valued and comfortable to speak up and take risks without fear of humiliation, embarrassment, judgment, or consequences (Chapter 4, section 4.5). This affirmed McClimens and Scott, (2007) who highlighted how the facilitator within Forum Theatre can foster openness to learning through modelling inclusivity and valuing learners.

This was also discussed by Rae (2013); Middlewick, Kettle and Wilson, (2012) and Kruger *et al*, (2005) who found that when Forum Theatre is facilitated well by the Joker, participants feel at ease and they are more emotionally open to giving and receiving feedback and investing themselves more fully into the process. The Joker role appeared to model inclusivity and group work facilitation skills which are key attributes required of a mental health nurse working within diverse teams and with the families/carers of patients (Dwyer, 2004; Jack *et al*, 2017).

Good facilitation in Forum Theatre is demonstrated when the Joker is able help the group move away from hierarchical power relationships by taking a democratic and person-centred approach to organising and facilitating (Love, 2012; Wasyklo and Stickely, 2003). The Joker's role was also discussed in relation to creating a safe learning environment within Forum Theatre (Love, 2012; Middlewick, Kettle and Wilson, 2012; Wasyklo and Stickely, 2003).

The qualities of the Joker highlighted by the participants were honesty, flexibility, respectfulness, and ability to communicate (Chapter 4, section 4.5). This is supported by the literature which states the Joker must have excellent communication skills (Jacob *et al* 2019), have an ability to foster participant learning (Love, 2012), provide immediate respective and constructive feedback, and maintains professional integrity (Himida *et al*, 2019). This models the competencies and values that are required of mental health nurses (Middlewick, Kettle and Wilson, 2012).

The findings demonstrated how the Joker's role was important in creating a psychologically safe learning environment from the planning, preparation, and orientation to the navigation through the narrative of the unfolding story in the Forum Theatre workshop. (Chapter 4, section 4.5). It needs to be understood by the person playing the role of Joker that it is a privileged position of power and is critical to the integrity of the learning environment (Coulter, 2018). This highlights the complexity of the role as discussed by Kemp, (2009) and Love (2012) who indicated a need for training and supervision. This study doesn't address training and supervision for the Joker role, however, reaffirms that this needs to be considered as a future action.

In summary, Forum Theatre within the context of this study offered mental health nurses a psychologically safe learning environment and foster their ability to avert defensive behaviours, feel empowered by their successes and is a tool to facilitate learning in relation to mental health nursing.

5.5 Authenticity (Subjective Experience)

5.5.1 Personal relevance – the actors role

The findings showcased the importance of quality of the acting and how the portrayal by the actor held personal relevance, reproducing an accurate practice experience (Chapter 4, section 4.6). Participants felt that this increased engagement and investment in their roles as SpectActors. These findings are aligned with McClimens and Scott, (2007) and Tuxbury, McCauley and Lement, (2012) who discuss the need for experienced actors and how well written scripts can lead to better engagement and more positive outcomes in Forum Theatre. Furthermore, participants felt that through their use of experienced actors they were able to engage and invest in the narrative and then learn more deeply than in previous learning exercises that had used simulation such as role play, building on previous findings (Himida *et al,* 2019; Kruger *et al,* 2005; Nordstrom, Fjellman-Wiklund and Grysell, 2011).

The findings built further on why quality of the acting and enhanced personal relevance was important by revealing how what appeared to be genuine exchanges of emotions taking place between the actor and the participants (Chapter 4, section 4.6). The dynamics between actor and SpectActors is complex, and due to the accuracy of the acting, genuine and similar feelings

were evoked in participants that they experience in practice, carrying a high level of personal relevance, this was in keeping with concepts discussed by D'Ardis, (2014).

Without an authentic representation of practice, the intervention could be undermined because participants will not engage in a meaningful way (Felton and Wright, 2017). Authenticity in emotional exchange is very important in mental health nursing in learning how one responds and reacts to others, and how this can impact on communication and rapport (Harris and Panozzo, 2019). This is especially true of working with people who maybe experiencing thoughts of self-harm or suicide (Norman and Ryrie, 2018).

An authentic representation and response enabled reflection on real emotions. This is something a mental health nurse will need to be able to do in practice due to the unconscious transference issues under the surface of the exchange (Brett-MacLean, Yiu and Farooq, 2012; D'Ardis, 2014; Kemp, 2009; Middlewick, Kettle and Wilson, 2012).

5.5.2 Creating realism

Further explanation for these findings can be found in how the actors used in this study were encouraged to draw on the Stanislavski system (Stanislavski, 2013c), (Chapter 3, section 3.5.3, Appendix 1). This system encourages role interpretation based on the inner impulses of the performer and allows for scenes to take unexpected new directions. This may have worked well for participants by creating a more improvised natural evolution of the scenario compared to something over scripted (Higgins and Nesbitt, 2020).

The actors for the session were given circumstances on the role (Appendix 1), (e.g. specifics of time and place: elements from the history of the character's environment (e.g childhood

emotional and physical; abuse, father alcoholic, bullied at school), and elements from the character's personal situation (e.g. works as a security guard, has been depressed for three months, could lose job as taking lots of sick leave). They were then encouraged to develop the character in their own way and through improvisation in response to the evolving narrative in the Forum Theatre play, thus drawing on Method of Physical Action (Stanislavski, 2013b).

5.5.3 Emotional connection

Through drawing on the Stanislavski system, the method of physical action and also working with the given circumstances the actors were able to develop the character in rehearsals and begin uncovering nuances of character and embody the role (Stanislavski, 2013c). This may have gone some way to explaining the experience, participants, who as mental health nursing students, would value the unpredictability, depth, and nuance of the actor's portrayal over a shallow stereotype (Kemp. 2009; Peterson, 2017). The findings (Chapter 4, section 4.6) evidenced how the actors would evoke feelings internally as they do with real patients, this therefore means that their emotional responses were similar and so addressing real emotions experienced in practice.

5.5.4 The essence of theatre

Further explanation for sense of authenticity, connection and the overall experience can be found in theatre pedagogy, which when distilled to its purest essence, relates to the unfolding of an encounter between spectator and actor, everything else is dispensable (Grotowski, 2012). There are only two essentials in theatre, the first is the actor and the second is the audience (Brecht, 2014). The encounter then needs to be meaningful with high quality acting, and personally relevant scenarios to create realism and genuine emotions that lead to intrinsic motivation to invest and immerse in the action and deepen the reflective process.

5.6 Active Learning: (Subjective Experience)

5.6.1 The SpectActor

The active learning theme represented activities identified in the findings that enabled mental health nursing students to learn within the Forum Theatre workshop explored within this study. The findings showed that participants valued the SpectActor role highlighting the opportunities to observe, exchange feedback, reflect and rehearse skills (Chapter 4, section 4.7). These findings were consistent with earlier studies that have identified how learning in Forum Theatre takes place. Middlewick, Kettle and Wilson (2012) highlighted how Forum Theatre allows for true critical application of knowledge and skills. Wasyklo and Stickley, (2003) discussed how Forum Theatre provides an opportunity to explore different ways and means of interpretating and approaching practice scenarios.

Previous studies have indicated how observation, and exchanges of views and knowledge using reflective analysis, problem-solving skills and drawing on complexities of practice experiences enhance learning (Middlewick, Kettle and Wilson, 2012; Nordstrom, Fjellman-Wiklund and Grysell, 2011). Through interaction with the play the SpectActors work together to shape and determine the narrative by drawing on prior knowledge, live reflection and taking part. It was common in the literature to see comparisons drawn between Forum Theatre techniques and experiential learning theory, affirmed by this study (D'Ardis, 2014; Kruger *et al*, 2005; McClimens and Scott, 2007; Middlewick, Kettle and Wilson, 2012).

5.6.2 Rehearsing skills

Use of prior knowledge and the ability to rehearse scenarios with personal relevance to challenges faced by mental health nursing students, and insights developed from feedback and reflection, is an example of instructional scaffolding (Vygotsky, 1978), whereby the social or informational environment offers supports for learning that are gradually withdrawn as learners become internalised and the narrative moves towards a positive outcome. The individual and the group gradually take control and Joker takes a step back (Bruner, 2020). The active learning approach used in Forum Theatre workshop at the centre of this study may be seen as an iterative process, and the learning builds and develops with further reflection and experience.

The subjective experiences of mental health nursing students undertaking the Forum Theatre workshop affirmed how these theoretical principles were applied to understand how learners were thinking and were used to enrich that thinking. The findings suggest that learners valued the constructivist approach over more behaviourist transmission models of learning that they had encountered previously (Chapter 4, section 4.7), (Barton *et al*, 2018). This was possible by using Forum Theatre techniques to actively apply mental health nursing skills drawn from real practice experience. The active involvement of the audience in the SpectActor role appears to be one of the defining features of Forum Theatre workshop for mental health nursing students, seeking to hand power to the group to shape the outcome of the play and learn skills.

5.6.3 The cycle of learning in Forum Theatre

Kolb's experiential learning cycle can be used as a framework to explain the findings further (Kolb, 1984). Kolb's cycle starts with a concrete experience; in Forum Theatre this would

equate to taking part as SpectActor in live reflection on the play or taking part on the stage. Key to learning for Kolb's model is that to be effective, learners need to take part in the action (Kolb, 2014).

The second stage in the cycle was that of reflective observation and perspective taking. For SpectActors these appeared to be periods when they were taking time-out from acting on stage, there may be a pause in events to allow a step back to review what had been experienced and the opportunity to ask questions of the other SpectActors, actor or observe others taking on the task (Jacob *et al*, 2019).

Abstract Conceptualization is the process of making sense of what has happened and involves interpreting the events and understanding the relationships between them (Arveklev, 2018). At this stage the learner makes comparisons between their own response and actions, reflecting upon what they already know. This was undertaken with encouragement from the Joker, participants use their own previous knowledge, models they are familiar with, ideas from each other, previous observations related to the scenario.

The final stage of the learning cycle is when consideration of how ideas and suggestions are going to be applied to practice. In the Forum Theatre workshop, this might involve some very brief planning and prediction of how modified/refined actions might benefit the interaction with the patient. The process then begins again, the new ideas are tested with the patient in the play in another concrete experience (Middlewick, Kettle and Wilson, 2012).

5.7 Personal Development (Subjective Experience and Specific Skill Sets)

Personal Development emerged as an overarching theme to capture how mental health nursing students had experienced improved communication skills, increased resilience, and increased sense of empathy after taking part in the Forum Theatre workshop focused on crisis intervention.

5.7.1 Communication Skills

5.7.1.1 Active listening through non-verbal communication

The findings demonstrated that participants appeared to gain insights into the effective use of active listening skills including awareness and use of non-verbal communication to demonstrate they were listening to enhance rapport (Chapter 4, section 4.8.5). This confirms suggestions from Nordstrom, Fjellman-Wiklund and Grysell, (2011) who found an increase of awareness of personal body language in their study on using Forum Theatre with medical students, however, there was nothing concrete in the previous literature on using non-verbal skills to rehearse and enhance communication.

To explain these findings and why they have been prominent in this study may have been the focus on mental health where active listening skills are of critical importance for communicating effectively (Barker, 2017). Forum Theatre allowed participants to become more aware of active listening skills, including non-verbal communication, understanding the power of silence, and their relation to verbal active listening skills such as feedback, clarification, and reflective summary (Chapter 4, section 4.8.5). Awareness is developed

through observation, feedback, reflection and rehearsing to develop their ability to understand and convey the skills required using body language with minimal verbal interaction (Norman and Ryrie (2018)

The insights gained are perhaps in part explained within the findings, where participants described the opportunity to observe and learn about verbal and non-verbal cues and receive feedback from the actor (Chapter 4, section 4.8.5). This allowed them to learn the value of active listening skills (Nordentoft and Oleson, 2021). Participants were perhaps able to see how this could lead to a catharsis of genuineness, helping prevent misunderstandings and misinterpretations (Brunero and Stein-Parbury, 2008).

5.7.1.2 Paralinguistics

The findings suggested the participants may have gained insight on how non-verbal expressions in tone and pitch of voice can either complement or contradict spoken word, impact on communication, and convey attitudes or emotions to patients (Chapter 4, section 4.8.5). This finding was mentioned by Nordstrom, Fjellman-Wiklund and Grysell, (2011) who found that Forum Theatre could raise awareness of how speech can affect communication, however, this didn't explore using Forum Theatre to rehearse and develop the skills, with a focus more on the reflective element.

It seems possible this finding could be due to how in the Forum Theatre workshop there was instant feedback in the shape of the patient response that can be seen, heard, and felt emotionally through the SpectActor role, with issues related to paralinguistics being highlighted as the play progresses. Because the Forum Theatre session at the centre of this

study (Appendix 1) is designed around crisis intervention, there is a lot of highly expressed emotion involved and therefore far more sensitivity to paralinguistics. The Forum Theatre workshop appears to have provided a platform to observe how a question or view can be perceived and be interpreted differently based on the tone and pitch of the voice.

Paralinguistics allow kindness and empathy to be displayed very naturally without relying on cliché or meaningless phrases (McCabe and Timmins, 2013). Mental health nursing students may have been able to see how paralinguistics can impact communication and convey attitudes or emotions to patients by engaging in the Forum Theatre workshop as SpectActors (Brown, 2015).

5.7.1.3 Questioning techniques

The findings identified how mental health nursing students may have learned to refine some questioning skills during the Forum Theatre workshop, for example, accurate use of open and closed questions, prompts, paraphrasing and clarification. These findings were generally confirmed across a range of articles (Jacob *et al*, 2019; Kruger *et al* , 2005; Middlewick, Kettle and Wilson, 2012; Nordstrom, Fjellman-Wiklund and Grysell, 2011; Tuxbury, McCauley and Lement, 2012). All those articles discuss positive outcomes from the use of Forum Theatre in developing communication skills. D'Ardis (2014) and Wasyiko and Stickely, (2003) consider mental health settings more generally and how Forum Theatre can be used to develop questioning skills.

This finding could be explained by the SpectActor role and stop/start of the scenario where suggestions on what might be preventing the narrative from moving forward are explored, and questioning discussed and rehearsed. Participants may then begin to see how using correct

questioning techniques allowed rapport to be built. They could perhaps see how this allows for the patient's voice and perspective to be heard and prevent a jump into their agenda too quickly. This may have avoided a mechanical, checklist approach, and participants were able to notice important cues to action to determine subsequent questioning. Participants may then have had the opportunity to see the impact of poor questioning and rehearse a more conversational and person-centred approach to asking questions. The result is likely that patients would feel more valued and genuinely cared for as an individual (Jefferies *et al*, 2020).

5.7.1.4 Having difficult conversations about suicide and risk

The findings suggested that participants valued the Forum Theatre workshop as it provided an opportunity to talk about their fears of conversations regarding risk and suicide with patients and rehearse those conversations safely (Chapter 4, section 4.8.5). There was no previous literature that discussed the use of Forum Theatre for having conversations regarding risk and suicide specifically, however, comparisons can be drawn with D'Ardis (2014) who indicated how Forum Theatre can be used for rehearsing difficult conversations in mental health. Difficult conversations were also addressed by Himida *et al*, (2019) Nordstrom, Fjellman-Wiklund and Grysell, (2011) and Tuxbury, McCauley and Lement, (2012) who indicate how Forum Theatre can be a pedagogy for developing skill in breaking bad news.

The reason for this finding could be explained by a common fear in mental health nursing that talking about suicidal thoughts and feelings could make a patient more likely to act on them by putting the idea in their head (Bell, 2021; Shea, 2016). This fear remains an issue despite evidence suggesting that asking patients about suicide does not increase the risk and is usually beneficial (Blades *et al* 2018; Dazzi *et al* 2014; Gould *et al* 2005). It appeared that participants were able to see that consequently, some of the questions they feared asking were helpful to

someone feeling suicidal, attributed to actors who are well briefed on how to respond based on evidence (Bolster *et al*, 2015; Joiner, 2011). The Forum Theatre workshop did seem to offer participants an opportunity to rehearse how to explore suicidality and trial out the effect of talking about suicide with an actor safely.

5.7.1.5 Challenging attitudes

The findings also showed how the Forum Theatre workshop may have challenged attitudes that surround self-harm and suicide (Chapter 4, section 4.8.5). For example, the belief and attitude that those who talk about self-harm/suicide are less likely to take their own life, are attention seeking and time wasting (Blades *et al* 2018; Dazzi *et al* 2014). Forum Theatre was an opportunity to see how these attitudes can be perceived and reinforce low self-worth, compounding levels of distress (Bell, 2021).

During the Forum Theatre workshop participants highlighted how they were able to see how unhelpful attitudes contributed to increasing the distress and risk with the patient. They were able to hear from the actor 'in role', how better to help, to feel listened to, and how patients needed their distress, to be validated by the nurse increasing empathy for the patient (Linehan, 2018). Myths, feelings, and fear about suicidality can be barriers in the nurse or patient reflecting personal values, beliefs, attitudes, and prejudices which can adversely affect the relationship (MacLean *et al*, 2017). The Forum Theatre workshop may have helped participants identify, reflect upon and challenge attitudes with view to reaching a common goal in helping the patient reduce their distress and enhance conversations about risk and suicide. The SpectActors in the Forum Theatre had an opportunity to see how when the actor misinterpreted the question, the problem was often due to how the question was asked rather than misunderstanding or misinterpreting on the part of the patient (Arveklev, 2015).

5.7.2 Resilience

The findings demonstrated how participants had experienced a sense of feeling more resilient in practice since taking part in the Forum Theatre workshop. Contributing to resilience were the insights into the patient experience, increased self-awareness, communication skills and understanding of using them to support a patient in crisis (Chapter 4.8.6).

The findings further support the ideas offered by McClimens and Scott (2007); Wilson, (2013); (Wasyiko and Stickely, 2003) who found that Forum Theatre provided an opportunity to experience how a patient can redirect feeling and frustration they have for others or the self on to the nurse. Furthermore, projection of a clinicians own unacknowledged emotional burdens can threaten the effectiveness of the nurse-patient relationship with the patient D'Ardis, (2014). Freshwater and Stickley, (2004) discussed how by developing self-awareness on the undercurrent of interpersonal relations practitioners are better able to navigate the relationship with appropriate professional boundaries.

Increased resilience could be linked to the direct work on skills development undertaken in the Forum Theatre workshop, SpectActors gaining new insights, have elements of their practice deconstructed, reflected upon, and then built back up with support and consensus across the group. Success was confirmed through the evolving narrative. The skills maybe very personal or shared challenges but with common objectives and goals.

When working with self-harm and suicide, participants may have felt more confident and less anxious when encountering patients experiencing suicidal thoughts in practice after taking part in the Forum Theatre workshop. Feeling safe in the workshop may have opened the mind to

deeper reflection, developed personal awareness, promoting creative expression and critical thinking among the mental health nursing students (Arkelev *et al*, 2015; Cangelosi; 2008).

The sense of improved resilience described by participants is a strong indicator on how the Forum Theatre workshop may have enabled liberation from external oppression in a very small way which is in keeping with Boal's intentions of Forum Theatre (Boal, 2000). For example, the impact of suicide and blame culture on their practice (Chapter 4, section 4.8.5). The pragmatic approach taken by the Forum Theatre workshop for mental health nursing students, allowed this approach to be taken from both the individual and social perspectives, to problem solve and develop skills in ways that were within a more immediate locus of control (Blair, Brioc and Schutzman, 2019). This may have helped mental health nursing students to improve their sense of resilience in practice. The Forum Theatre workshop appeared to offer quite a complete package for developing mental health nursing skills related to crisis intervention underpinning overall increase in subjective resilience.

5.7.3 Empathy development

The phase 1 findings (Chapter 4, section 4.4) suggested that participants experienced a subjective increase in empathy after undertaking a Forum Theatre workshop focused on crisis intervention for an emotionally distressed patient and this was confirmed in the phase 2 findings. The findings build on existing literature that discussed development in the healthcare field in relation to developing emotional intelligence (D'Ardis, 2014; Wayisko and Stickley, 2003) and development of empathy for patients through exploring stigma (Middlewick, Kettle and Wilson, 2012; Wilson, 2013). However, primary research focused on empathy development in health promotion such as anti-bullying (Aylett *et al*, 2007; Blackwood, 2017;

Burton *et al*, 2015; Edwards and Goodwin *et al*, 2019) with none that explored empathy more specifically with healthcare professionals.

The results for this study could be explained using personally relevant content in the Forum Theatre workshop that allowed learners to engage more meaningfully (D'Ardis, 2014; Kelley and Kelley, 2013). Personal relevance of the session may have been created by considering the needs of the individuals and group. Creating a Forum Theatre workshop that is centred on the needs of learners over a curriculum or teacher driven approach models empathic understanding (Williams and Stickely, 2010). This is enhanced by the Joker who promoted opportunities to explore perspectives and attitudes. Thus, creating an inclusive space to learn from and appreciate other points of view (Levett-Jones, Cant and Lapkin, 2019; Middlewick, Kettle and Wilson, 2012).

To explore perspective and attitudes, the Forum Theatre workshop encouraged active listening skills through the process of hearing from others and use of metacognition skills. These are suited to better understand motivations and perceptions of the self and others, contributing to better empathic skills (Doyle, Hungerford and Cruikshank, 2014). Ward *et al*, (2012) suggest an environment that encourages curiosity of what can be learned from others and their experiences to develop stronger understanding of those around us (Chapter 4, section 4.8.7). Finally, teaching and empathy development needs to be integrated into content and interactions, not something that is tagged on to a teaching session (Reynolds, 2017; Williams and Stickely, 2010).

The need for a combination of approaches to develop empathy skills could be explained by the domains of empathy. There is a consensus on key domains of empathy (Kelley and Kelley,

2013; Laughey, 2019; Yu and Kirk, 2009). The first domain defines empathy as the affective response to a person, referring to an immediate experience of the emotions of another person or the ability to comprehend the emotions of others (Bryant, 1982; Reynolds and Scott, 2000; Richardson, Percy and Hughes, 2015). The second domain defines empathy as cognitive awareness of another person's internal states (Gerace, 2020; Rogers, 1986). This can be seen as an intellectual understanding of another person's experience through observation and mental processing.

King (2011) added to the affective and cognitive domains of empathy with a behavioural domain and what was referred to as a communication domain by Hojat, (2016), King suggested that it was hard to envisage the affective, cognitive, and behavioural domains of empathy standing individually when applied to practice, and developed a conceptual framework of empathy in practice which was drawn upon by the researcher for the empathy development cycle (Figure 14)., This was in light of how it aligned with the process involved in the Forum Theatre workshops and empathy development.

King suggests empathy begins with affect sharing, followed by understanding the feelings of others, which motivates other related concern and finally ends in helping behaviour (Singer and Lamm, 2009). Sympathy and empathic concern can be seen as products of the affective domain, whereas empathy also requires actions of the cognitive and behavioural components (King, 2011; Price and Archibold, 1997; Singer and Lamm, 2009). How the results demonstrate the process of the Forum Theatre workshop informing empathy development across those domains will now be discussed. It is important to highlight how the researcher had no preconceived ideas when entering this study on how Forum Theatre might aid development of empathy, and this concept came from consideration of the results and reflection

on what they were saying in relation to the literature and the researcher's experience of Forum Theatre in practice.

The findings suggest that the Forum Theatre workshop on crisis intervention provided mental health nurses the opportunity to build awareness and skills around feeling, comprehending and resonating with the patient in the affective domain while still being able to distinctly separate personal emotion from that of others (Chapter 4, section 4.8.7), (Levett-Jones, Cant and Lapkin, 2019). The cognitive function of the phenomena is therefore the skill to actively reflect on and understand these emotions when interacting with a patient and reason about affective states of patient and self. This involves complicated cognitive functions including perspective taking and mentalising (Hojat, 2016; Ward *et al*, 2012) to understand what others are thinking or feeling, without necessarily resonating with that feeling state (King, 2011)

The cognitive function is essential and closely related to the behaviour domain which is about action taken in response to the understanding gained from a person's emotional state (Morse *et al*, 1992; Reynolds and Scott, 2000). By being in tune with the affective domain and cognitive domains, empathy can be communicated and help provided to a person (Richardson, Percy and Hughes, 2015). The balance between emotion and understanding the patient's perspective needs to be congruent (King, 2011) in order to select and use appropriate skills in the behaviour domain and communicating empathic responses (Wiseman, 1996).

The way the four themes Authenticity, Learning Environment, Active Learning and Personal Development integrate to contribute to skill development across the domains of empathy is the defining finding of this study for the reseracher. Examples in the literature for empathy development in nursing and healthcare tend to focus on specific sessions such as role-play to

develop empathic phrases (Cant and Cooper, 2017; Felkon and Wright, 2017). These might be useful for learning how to communicate empathy but, the ability to explore and learn how to manage affective empathy in relation to cognitive could be limited. Therefore, this could be viewed as a superficial approach to communicating that may not be felt or fully understood, and would likely be reflected in the patient experience (Wasylko and Stickely, 2007; Ronning and Bjorkly, 2019).

For example, watching a video of an intervention and analysing it in a classroom may trigger some affective empathy, and through analysis, some cognitive understanding (MacLean *et al*, 2018). However, this would all be from an observational point of view, at a distance, with no opportunity to practice behaviours and skills in a unified experience (Ward, Knowlton and Laneyl, 2018). Furthermore, this is less likely to be focused on areas that are specifically needed for the individual learner (Wright, 2011).

The skills involved in demonstrating empathy were able to be practiced in the Forum Theatre workshop on crisis intervention, such as active listening and paralinguistics. However, rather than being a solo exercise of practicing empathic statements, the Forum Theatre workshop of the current study promoted learning that was generated from the ground up through play. In the Forum Theatre workshop for crisis intervention the mental health nurse must respond in accordance with the patient's emotional states, and without developing awareness, the response from the patient would not necessarily be positive. Lack of awareness and over resonance with affective empathy could result in unpleasant feelings that are too much for the nurse to cope with, resulting in unhelpful behaviours and over identification or restrictive behaviours (Singer and Lamm, 2009).

When both cognitive and affective domains are involved in the process of informing empathic responses, actions have an altruistic quality (Levett-Jones, Cant and Lapkin 2019). The phenomenon of empathy requires all its three functions to lead towards positive behaviour. The skill of empathy could be described as cognitive and emotional attunement to another's experience and the ability to communicate understanding of that experience back to the patient (McCabe and Timmins, 2013).

There is some consensus on principles that underpin an environment that fosters development of empathy in learning. Richardson, Percy and Hughes, (2015) suggest that modelling respectful relationships with learners and managing emotions inclusively in the classroom can increase empathy in learners. Using content for learning that holds personal relevance allows for learners to engage more meaningfully (Hojat, 2016; Kelley and Kelley, 2013). This personal relevance is based on person centredness over a curriculum or teacher driven approach, modelling empathic understanding (Hojat, 2016; Williams and Stickely, 2010). Facilitators who take opportunities to teach points of views, to explore perspectives and attitudes, create a space to learn from and appreciate other points of view (Levett-Jones, Cant and Lapkin, 2019; Middlewick, Kettle and Wilson, 2012).

Activities that promote the development of active listening skills to hear from others, and the use of metacognition skills to understand the self, can contribute to better empathic skills (Doyle, Hungerford and Cruickshank, 2014). Ward *et al*, (2012) suggest an environment that encourages curiosity about what can be learned from others and their experiences to develop stronger understanding of those around them. Finally teaching and empathy development needs to be integrated into content and interactions, not a single session or something that is tagged on to a teaching session (Reynolds, 2017; Williams and Stickely, 2010).

5.7.4 Measuring impact of Forum Theatre on empathy

Phase 2 of the research used the Jefferson Scale of Empathy (Hojat, 2016) to measure pre and post Forum Theatre empathy and confirmed that there was a significant increase in empathy in mental health nursing students after taking part in a Forum Theatre workshop based on a crisis intervention simulation (Chapter 4, section 4.10). When mixed with the phase 1 results it was confirmed the themes drawn from the subjective experience strengthened the concept that Forum Theatre workshop for mental health nursing students may have helped develop their empathy skills (Chapter 4, section 4.12). One previous study that used the Jefferson Scale of Empathy on medical students pre and post Forum Theatre to explore difficult encounters with patients and families, did see a significant increase in empathy, post Forum Theatre (Sevrain-Goideau *et al*, 2020). This study suggested more work was required to examine long-term impact of Forum Theatre on empathy.

The explanation for the results on the Jefferson Scale of Empathy have really been stated through the discussion on the experience and skills development – that empathy development appears to be at the centre of the experience of the Forum Theatre workshop used in this study. While the significance is useful there were limitations. It would have been useful to have been able to conduct the questionnaire on a greater number of mental health nursing students. It may have been useful to capture patient perception of empathy in the longer term after staff had taken part Forum Theatre workshops, however, this would have gone beyond the scope of this study.

5.8 What conclusions can be drawn about the application of Forum Theatre techniques?

The findings of the current research suggest that empathy was at the centre of the experience of mental health nursing students undertaking a Forum Theatre workshop on crisis intervention. It was used pragmatically in a learning environment designed to address the psychological and sociological aspects required to move the narrative around a person's care to a positive outcome. This captured the 'me' and the 'we', creating individual development and social consciousness in line with Beard, (2018); Boal, (1974); Dewey, (1938) and models person centredness (Richardson, Percy and Hughes, 2015)

The environment was designed to be psychologically safe for participants, allowing them to feel valued, free of judgment and able to make mistakes (Chapter 4, section 4.5). This environment was largely created and supported by the Joker who models these values, and the skills from communicative domain of empathy (Chapter 2, section 2.4.10). Over the course of the Forum Theatre workshop SpectActors appear to share and model these skills (Chapter 4, section 4.5.8).

The personal relevance and realism of the scenarios and actor portrayals were seen as meaningful and authentic contributing to a sense of value in mental health nursing students, that Forum Theatre workshops were worth investing in. The personal relevance and realism of the scenarios and actor portrayal appeared to promote a deeper engagement in the narrative and genuine emotional encounters within the play during the workshop (Chapter 2.6.18). This appeared to contribute to emotional connection in the experience of the Forum Theatre

workshop and may have enabled an experience that can be ‘felt’ and ‘connected’ with in the affective empathy domain (Chapter 4, section 4.8.7).

The connection with the affective domain is very important because without it, cognitive empathy and behaviour empathy may run the risk of being approached in an overtly logical way. The result being a more artificial relationship with the patient reducing the quality of the therapeutic relationship. Furthermore, without an opportunity to evoke emotions in the Forum Theatre workshop on crisis intervention the mental health nursing students may not have received the opportunity to be challenged in such a way that tested their ability to regulate their emotions which could result in illogical responses to a patient (Chapter 1, section 1.3.9).

Creating an environment that focuses on all empathy domains, mental health nurses were able to have a more complete and authentic learning experience, albeit a safer one than they would with real patients (Chapter, section 4.5). The active learning techniques employed in Forum Theatre workshop on crisis intervention enabled new insights. For example, some development of skills required to communicate in ways to help the patient in the cognitive and behaviour empathy domains. These types of skills are fundamental to being able to empathise with others in a therapeutic way (Chapter 1, section 1.3.5).

In the Forum Theatre workshop on crisis intervention with mental health nursing students, empathy was integral, as the end goal was to communicate and to connect to help another person. It was important that the Joker was adaptable, observant with attunement to others to safely challenge and help SpectActors develop (Chapter 2, section 2.4). This required a high level of self-awareness as the Joker modelled how to manage emotions, understand perspectives, and communicate empathy.

By learning how to recognise emotions in others, how they impact oneself personally and how one's own responses may impact on the patient, mental health nursing students may have been able to use the Forum Theatre workshop at the centre of this study, to detach themselves enough emotionally to understand the challenges of the patients in a more genuine way. This new and developing insight into emotions may have allowed for more comfort in the interaction from the nurse's perspective. This may have increased the ability to ask difficult questions or discuss emotive issues such as suicide more confidently (Chapter 4, section 4.8.5). Increased empathy for others may reduce fear in nurses and liberate them from internal psychological fears and externally created social fears such as blame and criticism (Chapter 2, section 2.4.11).

The Forum Theatre workshop on crisis intervention for mental health nursing students appeared to combine the components of the four themes and subthemes together to create increased sense of empathy. While there have been various techniques used to teach empathy in healthcare, and specifically mental health nursing, the approach to using Forum Theatre in the current research appears to have integrated principles and techniques that could be considered a useful learning and teaching strategy related to mental health crisis support. The Forum Theatre and Empathy Development Cycle (Chapter 5, section 5.3) was a model that built on King's (2011) Structure of Empathy in practice to demonstrate how the Forum Theatre workshop contributed to empathy development through the affective, cognitive, and behavioural domains. This was developed through the synthesis of the results of the research in this thesis and by illustrating how the themes feed into developing empathy skills through the Forum Theatre workshop at the centre of the study.

5.9 Summary

The discussion has provided a deeper exploration into the meaning, importance, and relevance of the findings. The researcher explained and evaluated the findings in relation to the existing literature and research questions, leading to making an argument on the significance of the study. The discussion provided a deeper understanding on how the Forum Theatre workshop was a useful learning and teaching strategy for mental health nursing students to develop skills in delivering empathic care. A model was provided that illustrates how Forum Theatre can support a cycle of development across the affective, cognitive, and behavioural domains of empathy.

5.10 Field Notes

(Researcher field notes, May 2020)

My big challenge now is that my head starts popping with ideas, and I need to bring myself back to earth as I can begin to go off on various tangents that are beyond the scope of this project but are nonetheless interesting. More than ever, I need to take a step back and disengage from the work for a little while to get perspective back and revisit from a bird's eye view. When deep into thinking about the findings, the lines can become blurred between what is fact and what is fiction, and I can see how the researcher can be drawn by their imagination into new domains. Need to keep on track. I have periods of deep thinking and writing, even enlightenment occasionally followed by thought block, over saturation, and darkness.

At the time of writing, the world has been turned upside down by the Covid-19 Pandemic, and we need to adapt rapidly to new ways of working in mental health services. I recently put a call out across the trust for those interested in acting to use Forum Theatre to deliver training online. While there is a lot of power in the physical space and interaction in Forum Theatre, we are in an unprecedented situation. So I needed to do what I could with the resources I had. Amazingly, there has been lots of interest, so I have been developing and delivering essential training in response to learning, through the Pandemic using Forum Theatre techniques online. These have typically been two hours (bitesize) in length as we found that was about the max that is comfortable online. There has been massive support from the clinical directors, and the sessions so have been well received.

We have been busier than ever in our service and so a challenge now is to maintain momentum on writing up the thesis – so many challenges.

Chapter 6 Conclusion

6.1 Introduction

The conclusion summarises the study aim, objectives, and questions, and how they were addressed. A summary of the major findings is provided and their relationship with the previous research and limitations of the study are discussed. Implications for mental health nurse education and practice is explored with recommendations made for future action, policy, and research. A summary of the impact on practice from the accompanying portfolio of impact is provided before final thoughts and reflections conclude the chapter.

6.2 Recapitulation of Purpose and Findings

The purpose of the research was to explore the experience and impact of Forum Theatre techniques for developing mental health nursing skills (Chapter 1, section 1.4.13). There has been an emerging body of work that has aimed to explore and evaluate the use of Forum Theatre as a pedagogy in healthcare education. However, published research on the subject is limited to just a small number of evaluative studies. No primary research has explored the use of Forum Theatre for training mental health nurses. Despite the limitations, the literature has established that further exploration of Forum Theatre as a pedagogy in healthcare education was needed (Chapter 2, section 2.8.24).

The research aim was to understand the effectiveness of Forum Theatre techniques on mental health nursing skills by understanding how Forum Theatre was experienced, what specific

skills it addressed, and whether these skills impacted on practice (Chapter 2, section 2.9.25). A pragmatic lens permitted the researcher to encompass the strengths of other methodologies through a two-phase sequential exploratory mixed design (Chapter 3, section 3.4.9).

Phase 1 was qualitative, and the results informed the choice of measure for phase 2, which was quantitative. Phase 1 data collection was via eight semi-structured interviews and thematically analysed using Braun and Clarke's six-step method (Braun and Clarke, 2006). The phase 1 findings revealed that Forum Theatre increased empathy in participants, supported by four themes: 'Learning environment,' 'Authenticity,' 'Active Learning,' and 'Personal Development' with subthemes 'communication,' 'resilience' and 'empathy' (Chapter 4, section 4.4).

Phase 2 was designed to measure whether there was a significant difference in participant empathy before and after a standardised Forum Theatre workshop focused on a mental health crisis intervention. The Jefferson Scale of Empathy (Hojat, 2016) was used to measure participant empathy pre and post-intervention. A paired samples Wilcoxon test and Kruskal-Wallis test confirmed a significant increase in empathy in 95%, of cases confirming that Forum Theatre techniques increased participant empathy for others within the context of this study (Chapter 4, section 4.11.).

The combination of the four themes and how they interrelate appear to create an experience that may contribute to development of affective, cognitive and behaviour empathy skills in mental health nursing students who had undertaken a four-hour Forum Theatre workshop focusing on crisis intervention (Chapter 5, section 5.3). The first building block of this experience was based on the skill of the Joker and their ability to create a psychologically safe learning environment. The Joker role modelled inclusivity, reflective practice, and how to have

a deep understanding of mental health nursing practice. The Joker used in this study was well versed in active learning techniques and able to model empathy in their interactions with SpectActors (Chapter 5, section 5.4).

The second building block in the context of this study was authenticity, which was achieved by having well written scenarios that held personal relevance to mental health nursing practice, and accurate portrayal by actors. These components appeared to create meaningful engagement and an emotional depth to the interactions in the Forum Theatre workshop at the centre of this study (Chapter 5, section 5.5). The emotional depth of the scenario and role portrayal appeared to create a connectedness and may have contributed to a sense of care and the affective empathy. The exchanges were then able to be explored and better understood to raise new insights into individual and social behaviours related to supporting someone in emotional distress. Furthermore, the effort to create this authentic experience to help mental health nursing students develop skills seemed to be 'felt', forming the fabric of the experience.

These building blocks appear to have provided a strong base in the Forum Theatre workshop for active learning techniques to thrive. SpectActors learned through observation, live reflection, exchanging feedback and rehearsal of the play to direct the narrative to positive outcomes (Chapter 5, section 5.6). The active learning techniques that took place in the Forum Theatre workshop appeared to have provided an opportunity for mental health nursing students to better understand and balance their feelings across the affective and cognitive empathy domains. Thus, they could then modify behaviours, utilising communication skills that helped the distressed patient rather than hindering themselves.

Communication skills appear to have been developed in the Forum Theatre workshop on crisis intervention through active learning techniques, based on authentic scenarios and real emotional exchanges with actors. Because there was little room for passivity, the Forum Theatre workshop was not experienced as a superficial endeavour and focused on transformative change for the individual (Chapter 5, section 5.7). Some personal development may have developed during the Forum Theatre workshop for mental health nursing students through the cycle of active learning (Chapter 5, section 5.6). For example, communication skills that contribute to communicating empathy are worked on with each rehearsal of the play, such as active listening and having difficult conversations (Chapter 5, section 5.7.1).

The rehearsal of skills in the Forum Theatre workshops at the centre of the study may have helped mental health nursing students refine their abilities in positive behaviours and communicative empathy. Furthermore, by connecting with each other, empathising with the patient in the play, and developing skills, participants appeared to feel more resilient and open to learning after taking part in the workshop (Chapter 5, section 5.7.11). Some participants felt a renewed sense of resilience in relation to supporting someone in crisis in practice. This appeared to be through a sense of improved understanding of the impact of the self in relationships, understanding the patient's perspective, skills in rapport building, and having difficult conversations such as discussing suicidality.

The integration of these factors appeared to form a sense of completeness to the experience of Forum Theatre workshops for mental health nursing students. The Forum Theatre workshop used within this study appeared to integrate an active, and psychologically safe learning environment by using authentic scenarios tailored to meet the needs of mental health nursing students in supporting individuals experiencing mental health crisis.

Therefore, the significance of this study for mental health nursing practice is in how it informs understanding of Forum Theatre techniques when delivered in the current context as a learning and teaching strategy, for use with mental health nursing students to develop skills in delivering empathic care to individuals in mental health crisis. The model provided in (Chapter 5, section 5.3) illustrates how the Forum Theatre workshop used in this study may support a cycle of development across the affective, cognitive, and behavioural domains of empathy in a simulated mental health crisis intervention.

6.3 Relationship with Previous Research

These findings are broadly in harmony with the literature (Chapter 2, section 2.9) and built on concepts explored rather than challenging previous understanding on the modelling of positive power relationships and relation to the function of the Joker role (Kettle and Wilson, 2012; Kruger at al, 2005; McClimens and Scott, 2007; Middlewick, Kettle and Wilson, 2012; Rae, 2013). For example, how the Joker can help the move away from hierarchical power relationships by taking a democratic and person-centred approach to organising and facilitating (Love, 2012; Wasyklo and Stickely, 2003). The power of Forum Theatre in fostering of inclusivity, communication, and openness to empower learners and creating a psychologically safe and ideal learning environment (D'Ardis, 2014; Kruger at al, 2005; Wasyklo and Stickley, 2003; Rae, 2013). Restrictive practices were addressed through empathy development and becoming more aware of the risks associated with acting on the affective domain of empathy without cognitive understanding (McClimens and Scott, 2007; Wilson, 2013).

This study affirmed the importance of quality of acting and script to the integrity of Forum Theatre (McClimens and Scott, 2007; Tuxbury, McCauley and Lement, 2012) and how this enhances the experience in contrast to other forms of teaching as discussed by Himida *et al*, (2019); Kruger *et al* (2011); Nordstrom, Fjellman-Wiklund and Grysell, (2011). Creation of realism was discussed in relation to established theories (Boal 1974; Brecht, 2014; Grotowski, 2012; Stanislavski, 2013a), (Chapter 2, section 2.6.3).

The active learning component in relation to the SpectActor and the role it plays in raising self-awareness through reflection and rehearsing was addressed (Kruger *et al*, 2005; Middlewick, Kettle and Wilson, 2012; Nordstrom, Fjellman-Wiklund and Grysell, 2011). These concepts were drawn together confirming ideas presented in previous literature that the combination of the facilitator role, safe space, personal relevance, engagement, problem-based learning, transfer of prior knowledge and reflective practice are important components of Forum Theatre (D'Ardis; 2014; McClimens and Scott, 2007; Wasyklo and Stickley, 2003). The Forum Theatre process including skills rehearsal was found to align with experiential learning and scaffolding theories by Kolb (1984) and Vygotsky (1978).

The findings built on existing literature that discussed specific skill sets, including non-verbal communication (Nordstrom, Fjellman-Wiklund and Grysell, 2011), questioning techniques (Jacob *et al*, 2019; Kruger 2005; Middlewick, Kettle and Wilson, 2012; Tuxbury, McCauley and Lement, 2012) and asking questions in mental health settings (D'Ardis, 2014; Wasyiko and Stickely, 2003). Paralinguistics and non-verbal communication were also discussed and deemed more unique findings with only Nordstrom, Fjellman-Wiklund and Grysell, (2011) alluding to these skills in very different settings.

Using Forum Theatre to rehearse difficult conversations about risk and suicide was a finding from this study and discussed in relation to papers 'delivering bad news' (Himida et al, 2019; Nordstrom, Fjellman-Wiklund and Grysell, (2011); Tuxbury, McCauley and Lement, (2012). The findings confirmed the idea that Forum Theatre could be useful for rehearsing conversations in mental health settings as suggested by D'Ardis (2014). Improved resilience through undertaking Forum Theatre, including insights and increased self-awareness were also discussed (McClimens and Scott 2007; Wasyiko and Stickely, 2003; Wilson, 2013).

Perspective-taking and the role this plays in understanding others was discussed in the literature (D'Ardis, 2014; Wasyklo and Stickley, 2003) and developing empathy through learning about stigma (Middlewick, Kettle and Wilson, 2012; Wilson, 2013). However, none of the literature attempted to define empathy with the focus being on other aspects of Forum Theatre (Chapter 2, section 2.6.2). Empathy was therefore discussed in terms of the new findings in this study and relevant literature introduced to support the discussion.

Key authors exploring the use of Forum Theatre in mental health (D'Ardis, 2014; Middlewick, Kettle and Wilson, 2012; Wilson, 2013) identified the need for mental health nursing specific research in the use of Forum Theatre in nurse education. It must be noted that there was no primary research on the use of Forum Theatre in mental health nursing, and this project confirmed and refined some of the ideas discussed in the literature reviewed while highlighting limitations and areas for future action and study.

6.4 Limitations of the Study

Several limitations were highlighted from the discussion and are reflected upon in more detail here. First, the study sample was limited to mental health nursing students working in one part of the UK. From the quantitative perspective, the sample was relatively small and would be improved by a much larger sample representing mental health nursing students from across the UK for a more robust measure of impact (Chapter 3, section 3.5.12). However, setting up a Forum Theatre workshop is incredibly resource-intensive and Joker's need training on the skills. It may at this stage have been unrealistic to have delivered anything much bigger. This may become possible in the future if Forum Theatre continues to grow as a pedagogy for use in mental health nursing education.

The study was focused on the experience of mental health nursing students and their perceptions of Forum Theatre in both phases of the design. It would be valuable to explore whether the skills involved delivering empathy has any impact on real world patient experience. A follow up study might explore patient experience of mental health nurses who have undergone training using Forum Theatre techniques to develop empathy.

While this study provides a snapshot in time based on the interviews and pre-post intervention questionnaire, it did not by design consider longitudinal experience and effectiveness in practice. While the interviews did give some indication of a sense of improved resilience in practice, this was considered within a reasonably tight timeframe of a few months and didn't capture effectiveness. Future studies might consider use of Forum Theatre over an extended period and explore the application of the skills in practice.

It became evident when analysing and discussing the results of the research how important the non-verbal communication aspects and general interaction between the SpectActors and the actors played, furthermore how important the realism and authenticity of the play was to Forum Theatre's effectiveness (Chapter 4, section 4.4). In hindsight, it may have been useful to have considered filming the sessions for analysis and contrast with the interview data. Video information could also have been used within the analysis and discussions to highlight key points to the reader. These are learning points that can be considered for future studies.

The focus group (Chapter 4, section 4.9) undertaken to share the results of the research with those who undertook the interviews, led to some interesting insights that could have been built upon as a way of triangulating findings of interviews with group consensus on using the skills in practice. However, this would involve a different research design and so was beyond the scope of this study. This highlighted how a focus group may have bought some different insights compared to individual interviews and be worth using in a subsequent study.

Finally, there were no interview questions specifically relating to learning processes or specific skills (Chapter 3, section 3.5.16), which, upon analysing the data, appear to be concepts of some importance in the study. This is perhaps one of the weaknesses of an exploratory study but does suggest a direction for further research.

6.5 Implications for Practice

The study indicates that Forum Theatre techniques as used in this study have potential to be a helpful learning and teaching strategy for developing skills in delivering empathic care to

patients experiencing mental health crisis. It could be useful in higher education institutions that deliver mental health nursing courses and in practice for professional development.

The Forum Theatre techniques used within this study appear to be helpful for developing a range of skills pertinent to mental health nursing, namely awareness of affective empathy, cognitive understanding of empathy and skills in communicating empathically that are known to contribute to therapeutic relationships (Chapter 1, section 1.3.6). Those who undertake a similar Forum Theatre workshop to the one explored in this study may feel they are able to improve their resilience to challenging crisis interventions and specific skills in reflection, self-awareness, active listening, paralinguistics, and questioning.

For Higher Education Institutions, National Health Service Trust and maybe other care providers, the Forum Theatre workshop at the centre of this study suggests that the approach can be delivered in a way that promotes psychological safety through valuing learners and providing a space where it is okay to make mistakes without fear of blame, criticism or doing harm to a patient as could be the case in practice (Chapter 1.3.10).

Organisations considering using Forum Theatre could consider a training package for facilitators taking up the Joker role as the participants from the current study have indicated how the Joker role was important in creating a safe learning environment (Chapter 2, section 2.8).

It would be important that organisations and individuals planning to use Forum Theatre as it has been delivered in this study, to understand the importance of the integration of factors that form the experience. That is the integration of an interactive, and psychologically safe learning

environment that uses authentically written and acted scenarios tailored to meet individual needs of mental health nursing students.

6.6 Recommendations

The following recommendations have been drawn from the limitations and implications of the study.

For future action and policy:

- Higher Education Institutions and healthcare providers could consider Forum Theatre techniques in their learning and teaching strategies for skills development.
- An instructional model for providers would be a useful resource to produce and evaluate in the future which could provide details on delivering Forum Theatre techniques in relation to mental health care.
- A training package for the Joker role should be considered.

For future research:

- Future studies could consider the longitudinal experience of Forum Theatre to explore progress over time exploring skills in practice and whether the phenomenon of increased empathy is reflected in the patient experience.
- Exploration of transferability across the wider healthcare and social care professions.
- Exploration of therapeutic use of Forum Theatre for supporting patients, carers and families.

6.7 Summary of Impact on Practice

As an addendum to the thesis, a portfolio of the impact on nursing practice was developed and accompanies this document. The portfolio demonstrates how the study has influenced learning

and teaching strategy at University of West London and the suicide prevention strategy for a local NHS Trust and network of local authorities. It also provides details of how Forum Theatre has been used both in nursing practice and the university across a range of different subject areas that included pre- and post-registration nursing courses, non-medical prescribing, conflict resolution for inpatient mental health nursing staff, crisis resolution for mental health practitioners and suicide prevention training for staff in a local NHS trust.

Forum Theatre has also been used in brief psychological intervention training and with carers of mental health service users. Furthermore, details of an evolution of Forum Theatre techniques into an immersive theatre event using multiple actors to provide pre-registration nursing students an opportunity to practice responding to a critical incident are provided. This event was short listed for a Nursing Times Teaching Innovation Award of the Year for 2019.

Adaption in the Covid-19 pandemic is also provided with details of a move to using online technologies to deliver Forum Theatre online to train staff when face-to-face training had been stopped to reduce the spread of infection. Forum Theatre was used to address challenges faced by mental health nurses during the pandemic, such as safety planning, health anxieties, transitions through services and crisis telephone support. Work was also done with teaching staff who worked in an adolescent unit on professional boundaries.

The portfolio also highlights conference appearances, publications that have either informed or been informed by the study. Details of a teaching fellowship awarded to the researcher for teaching innovation are provided. Impact of the on the researcher, his practice and how to ensure lasting impact is discussed and account of being a professional doctorate student with reflections on the journey through the various assignments is provided.

6.8 Final Thoughts from the Researcher

Boal described empathy as the most powerful weapon (Boal, 2000). It can be a force for the best in human nature, and the worst if the affective is not tempered by the cognitive domain. Lack of understanding and managing empathy can lead to problems with professional boundaries resulting in entanglement with patients or restrictive practice. This can lead to unintentional harm to patients and to mental health nurses, such as stress, burn out and unhelpful culture in services. For the patient, it can result in unmet needs, increased distress and lead to potential harm.

For most people entering the mental health nursing profession, there is likely to be an intrinsic motivation to help others. It is therefore important that all is done to provide training that can help them build on these positive characteristics, to be able to use them positively, and develop personally and professionally. We owe it to service users of mental health services when they at their most vulnerable, to train mental health nurses to the highest standards.

Ultimately, the Forum Theatre techniques used within this study appear to combine a range of strategies and embed them in an integrated approach that inherently models and enables the development of empathy into a helpful learning and teaching package. There are many other benefits, but empathy is at the centre and allows for other specific learning to develop. The learning environment and authenticity components include psychological safety, aesthetics and underpin a connection to the affective domain of empathy – the experience is a sense of connection, feeling safe, and therefore ability to connect in the moment.

6.9 Field Notes

(Researcher field notes, July 2021

Since undertaking this study, I have been on a personal and professional development journey that has been long, often intense, and invaluable. I have new insight and understanding of what research is and the cyclic, often untidy yet equally methodical experience of progressing through a research project. I have learned that there is a multiverse of opinions and ideas, which can be frustrating. The process of undertaking research tested my resilience and challenged my values, self-awareness, and positioning in the world. The journey has been a combination of excitement, boredom, undoing, and rebuilding but ultimately humbling and rewarding. It is highly satisfying to draw this study to a close and look to the future.

Going forward, I intend to build on the work done and explore Forum Theatre in new contexts in healthcare and ways it can be utilised to help individual staff, teams, patients, carers, and families. The research process has encouraged me to view my own research within the broader educational and healthcare fields. In addition, it has provided an abundance of networks and resources from which I can draw from and contribute to improving the quality of healthcare education and experience of healthcare services.

I liked this little quote from Augusto Boal, which I think sums up the power of theatre in a sentence:

"It is not the place of the theatre to show the correct path, but only to offer the means by which all possible paths may be examined."
— Augusto Boal

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Appendices

Appendix 1: Workshop Guide and Actor Brief

Format of Forum Theatre Workshop – Mental Health Crisis Intervention Workshop Guide

Session	Content guide	Timeframe
Introduction to the workshop	Preparing the non-actors: • Getting to know each other • Building trust (Ice breakers) • Discussion about challenges faced in practice and crisis intervention • Preparing for the play	45 minutes
The play	The play delivered in full by the actors Scenario – Sam Jones (Actor brief attached)	10 minutes
Discussion	The Joker uses open questioning (non-suggestive and non-judgmental) • ask the group to describe the play with their own words/from their point of view; • to define as a group what is problematic in the play and needs change/action; • to recall and share real life situations similar to what happened in the play; • to debate and decide as group if they want to change the reality of the play; • to analyse each character and decide as a group what might be going on for them • Joker shouldn`t disclose the intended scenario, it may happen that the audience identifies one character differently than it was planned, the Joker should validate their interpretation and continue the show in the logic of the SpectActors. • The Joker should adopt the vocabulary of the audience – e.g. manipulating, attention seeking, kicking off etc. • Summarise the thoughts of the group back to them Next Step; Joker informs the SpectActors that the play will run again, but this time, they will have the option to intervene and try to influence the course of actions.	30 minutes

The Forum	In the Forum stage, the SpectActors will witness a rerun of the play, but this time, they will be given the chance to interfere. The Joker will explain to the SpectActors that their solutions will change the play. The Forum has the following rules: • Whenever a SpectActor wants to propose a change in the play, he/she should shout "STOP' and the play will freeze. • The SpectActors can change the behavior of any character except the patient (actor) (Change in behaviour in the patient will come through improved interpersonal communication from the nurse (SpectActor). • By turn, the SpectaActors must join the stage and demonstrate (rehearse) their proposal • The solutions proposed by the SpectActors will be integrated in the play only if the audience (other SpectActors) agree that they should try and that they are realistic. • Suggestions and interventions attempted will reflected upon and briefly discussed at each freeze in the action. • The play is likely to come to a natural conclusion – hopefully with an improved outcome – there is no such thing as a perfect outcome.	90 mins approx
Final Reflections and debrief	The Joker narrates the initial scenario of the play, then asks SpectActors to recall all the changes they have made and share their feelings about what happened and the outcome. The Joker asks the group to think and share what would they do differently in their practice following the experience and consider take away learning points. The Forum Theatre is a powerful experience for SpectActors. The Joker should help everyone to step out of their role and share any final thoughts or feelings. This should be restorative for SpectActors, reminding them that it has been about safely learning from each other.	60 mins approx.

Joker Role Further Information

Joker role – Forum Theatre and Mental Health Crisis Intervention
During the debate and the forum, the attitude, the phrasing and the body language of the Joker are crucial to create a safe and encouraging space for SpectActors to empathise with the

characters, confront poor practice, come up with interventions, demonstrate their ideas and share feelings, hopes or real-life experiences from practice.

The Joker:

- Is able to follow the structure of Forum Theatre
- Is familiar with the type of practice situation shown in the play and the realities of the audience
- Should never be judgmental with the audience` beliefs, opinions and interventions
- Engages the audience and involves as many SpectActors as possible
- Struggles to be as neutral as possible, asks questions, doesn`t express opinion (it is normal to have an opinion, is just important to not disclose it)
- Encourages the audience to take action without appraising their solutions, but by encouraging critical thinking
- Is comfortable with public speaking and moments of silence – SpectActors may need some time before being ready to intervene in the play or speak their mind
- Keeps calm and enforce the rules of Forum Theatre even when SpectActors get overly enthusiastic (don`t listen to each other, get distracted from the main problem, monopolize the debate etc.)
- Picks up and uses the SpectActors language and logic
- Repeats the SpectActors` proposals so that everybody hears them
- Gives clear directions
- Speaks clearly and with good volume to cut through
- Is flexible and creative
- Manages time wisely

Actor's Brief

Mental Health Crisis Intervention – Actor's brief	
Character name:	Sam Jones
Age:	33
Lives in..	A flat in West London
D.O.B:	23/02/1988
Background:	Sam was born and grew up in West London. His first contact with psychiatric services was when he was 12. Sam had a chaotic childhood and as an adult went on to disclose that he had suffered emotional, physical and sexual abuse by his father. Sam experienced bullying at school, got into using substances to self-medicate and increasingly got involved in playing truant and antisocial behaviour. Sam was referred to CAMHS aged 12, at the time his mother was concerned that he might have an ASC due to anxiety, issues making friends and angry outbursts. He was seen by Child and Adolescent Mental Health Services with no ASC recorded. They felt that trauma was impacting development, mood and behaviour.

	Sam spent periods in a 24/7 placement for respite when things became difficult at home and went on to live with older sister Jenny who described getting out of the family home as soon as she could to escape their abusive father. She described her mother as a broken woman had turned to alcohol to cope. Sam and Jenny remain close and she is one of the few people he trusts. Jenny says she does her but does find it hard and wishes there was more support available. At age 23, Sam was admitted to an acute MH unit under section three over concerns of suicide risk. Sam was diagnosed with emotionally unstable personality disorder. He struggles to manage intense emotions, can be impulsive and struggles maintain relationships with people. When well Sam enjoys spending time with his sister and has a keen interest in history. He hasn't many close friends and feels he has been exploited by others in the past. Sam has recently left his job as he didn't get on with his boss. His mum passed away a year ago of cancer, Sam had hoped work on their relationship as he hadn't seen her for a number of years. His father tried to make contact around the time of the death and this has all put Sam into turmoil.
Psychiatric History	• History of depression and emotionally unstable personality disorder. • Admitted to acute admission unit ten years ago – section 3 re risk of suicide. • Referred for psychology and Crisis Teams several times but poor engagement – doesn't like the workers. • Two previous known attempts to end life – 3 x Paracetamols three years ago and hanging from tree – one year ago. • History self-harm by cutting and burning skin on legs and arms
Socioeconomic background i.e. work:	You gave up your job at the local Esso garage three months ago as you didn't get on with your boss, he targeted you lot and belittled you in front of other workers. This always seems to happen and so you have never been able to hold down a job for long. You have no savings and generally live hand to mouth and have credit card debt of £8000 that you are unable to pay off, you expect the bailiffs to visiting at some stage.
Scene	You have been referred to the crisis intervention mental health team by your GP after you saw earlier that day. He had explained he was worried about you due to been very tearful in recent visits to get your medication. You are very sceptical of the mental health services after having a bad experience ten years ago when you got admitted on a section after telling

	the police you were going to end your life on a carpark. Therefore, not very forthcoming and suggest that they are not interested in helping. You find it hard to contain your emotions at times and may become upset – you can be quite changeable (but keep it subtle – base responses on how you would feel if you were in this person's shoes). The scene will take its own natural direction but when you feel supported and cared about you will be more open and engage better. The facilitator will help guide alongside the active audience members
Important information for the role in relation to risk of self-harm and suicide.	If asked, you have been burning your skin on your arms and legs with a lighter when feeling really intense – maybe a few times a week. You are not seeking medical help. This gives you some relief from pain. Don't share that you are suicidal unless you feel that you can trust the nurse and they ask the question. Don't share your suicide plans and methods unless the nurse explore this with you. You may get asked if you have any dates, plans or made arrangements around ending your life. If you feel comfortable then share that you have made a plan to end your life by hanging on the anniversary of your dad's death and have arranged for Austin to stay with a friend. If asked, you have tried to take you own life twice before – Overdose of about 30 paracetamol a few years ago and by hanging last year. You didn't call anyone for help and there was no one around. You were sick after taking the paracetamol and a branch snapped on the tree you used to hang yourself. Only offer information if sensitively explored by the nurse. If asked by the nurse protective factors are your dog Austin but you think he would be better of with a new family who can walk him properly. You don't have plans for the future – it seems bleak, what's the point to it all…
Actor preparation tips	Stanislavski system for preparing from this role. We aim to make these roles very naturalistic and avoid stereotyping mental illness. Consider these steps developed to help actors to build believable characters: 1. Who Am I? 2. Where Am I? 3. When Is It? 4. What Do I Want?

	5. Why Do I Want It? 6. How Will I Get It? 7. What Do I Need to Overcome? Feel free to use the given information and build your character as you wish – we prefer not to over script and let the play evolve naturally through improvisation. Link for more info on prep: https://www.dramaclasses.biz/the-stanislavski-system

Appendix 2: JBI Critical Appraisal Checklist (Examples)

JBI Critical Appraisal Checklist for Qualitative Research

Reviewer: Reuben Pearce	Date:	
Author:	Year:	Record Number:

		Yes	No	Unclear	Not applicable
1	Is there congruity between the stated philosophical perspective and the research methodology?				
2	Is there congruity between the research methodology and the research question or objectives?				
3	Is there congruity between the research methodology and the methods used to collect data?				
4	Is there congruity between the research methodology and the representation and analysis of data?				
5	Is there congruity between the research methodology and the interpretation of results?				
6	6. Is there a statement locating the researcher culturally or theoretically?				
7	Is the influence of the researcher on the research, and vice- versa, addressed?				
8	Are participants, and their voices, adequately represented?				
9	Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?				
10	Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?				

Overall appraisal	Include:	Exclude:	Seek further info:

Comments (including reason for exclusion)

JBI Critical Appraisal Checklist for Text and Opinion Papers

Reviewer: Reuben Pearce	Date:	
Author:	Year:	Record Number:

		Yes	No	Unclear	Not applicable
1	Is the source of the opinion clearly identified?				
2	Does the source of opinion have standing in the field of expertise?				
3	Are the interests of the relevant population the central focus of the opinion?				
4	Is the stated position the result of an analytical process, and is there logic in the opinion expressed?				
5	Is there reference to the extant literature?				
6	Is any incongruence with the literature/sources logically defended?				

Overall appraisal	Include:	Exclude:	Seek further info:

Comments (including reason for exclusion)

Appendix 3: JBI Data Extraction Tools

JBI QARI Data Extraction form Qualitative Research (Example)

Publication reference:
Record number:

Study Description
Methodology:
Method:
Phenomena of interest
Setting:
Geographical:
Cultural:
Participants:
Data analysis:
Authors conclusions:
Comments:
Complete:

Findings	Illustration from Publication (page number)	Evidence is Unequivocal	Evidence is Credible	Evidence is Unsupported

Extraction of findings complete Y

JBI Data Extraction Tool for Text and Opinion Publications (Example)

Publication reference:	
Record number:	
Type of text	
Population represented	
Setting/Context (maybe clinical, cultural, geographical)	
Stated allegiance/position	
Reviewers conclusion	
Notes	

Appendix 4: Included Articles, their Characteristics and Contribution to the Three Themes

Author/ Country	Title	Source/Type/Method/Participants/Data Collection	Findings/Key Points	Link to three descriptive themes
Middlewick et al (2012) UK	Curtains up! Using forum theatre to rehearse the art of communication in healthcare education	Peer reviewed journal. Commentary / discussion of lecturers shared experience. Nursing students. Student evaluation and informal feedback.	Low risk to patients. Developing emotional competence through active participation. FT needs a safe environment. Challenging conversations. Further exploration needed – type of learning and impact on practice. Links complaints with poor communication – empowering healthcare professionals. Developing communication skills and building relationships. Engages learners in deeper reflective thinking	1 – 2 – 3 X X
D'Ardis (2014) UK	Forum theatre for practice simulation and skills development in nurse education: a student's perspective.	Peer reviewed journal. Reflection. Observations of a conference. Mental Health Nursing Students.	Complex situations More research needed to assess the impact of FT Ensure patient voice is heard in the making of a nurse. Interpersonal and communication skills Allows the luxury of analysis that real life rarely affords us. Rehearsal space for difficult conversations. Suggest self-report emotional intelligence scale pre and post workshop.	1 – 2 – 3 X X X
Wilson (2013) UK	Let's All Play 'Stigma': Learning together using Forum Theatre in collaboration with mental service users and nurse lecturers	Unpublished. Academic / university website. Commentary of lecturer experience. 2nd year undergraduate students and mental health service users. Student written feedback.	Communication skills Helped raise awareness about stigma Power relations FT enabled re-enactment of service user narrative. Demonstrates an emerging body of FTs application in nursing/healthcare.	1 – 2 – 3 X X X
Kemp (2009) UK	Exploring empowerment issues with student midwives using forum theatre	Peer reviewed journal. Commentary / discussion of lecturers shared experience. Undergraduate students – Midwifery. Informal feedback.	Managing complex relationships. More rigorous / peer reviewed action research needed. Uses FT to challenge horizontal violence - to address complex issues of power relations in midwifery and disengaging birthing partners. Recognise potential for adaptation address other aspects of the curriculum. Safe environment. Collective empowerment (through sharing views/ideas/observation). Role of expert facilitator vital.	1 – 2 – 3 X X
Tuxbury et al (2012) USA	Nursing and Theatre Collaborate: An End-of-Life simulation using Forum Theatre	Peer reviewed journal. Evaluation of teaching strategy. Small scale pilot project (no methodology). Undergraduate adult nursing students.	Communication and challenging conversations. More evaluation of FT needed. Realism of scenarios and use of actors. Students felt more confident in recognizing changes in patients end of life condition. Observing their peers and being actively involved in shaping the narrative. Students found re-enacting situations that were difficult useful for learning. Getting realistic practice in an area students may not get much exposure too.	1 – 2 – 3 X X
Themes: 1: Role Modelling Positive Power Relationships 2: The Learning Process. 3: Developing Communication Skills				

Included articles, their characteristics and contribution to the three themes – continued.

Author/ Country	Title	Source/Type/Method/Participants/Data Collection	Findings/Key Points	Link three descriptive themes
McClimens and Scott (2007) UK	Lights, Camera, Action! The potentials of forum theatre in a learning disability program	Peer reviewed journal. Commentary / discussion of lecturer experience. Learning Disability nursing students. Literature review / reference to session.	Power relation student/teacher - Students find their own solutions not the teacher. Need for more participatory research for social change. How in FT discussion becomes actions and new scenarios are created. Reflection to action (continuous process). Students bringing problem from practice, explore alternative course of action. Impact diagnosis may have on individual – heightened awareness. Safe challenge. Inclusive learning Engaging – enjoyable for students – motivate to learn.	1 – 2 – 3 X X X
Kruger et al (2009) South Africa	Communication skills for medical/dental students at the University of Pretoria: lessons learnt from a two-year study using a forum theatre method	Peer reviewed journal. Action research. 2nd year students medical/dental. Data collection (semi-structured interviews).	Challenge attitudes. FT can transfer knowledge of communication skills. Action research approach good as able to address issues identified in the first stage. Future studies should focus on problem solving i.e. communicating in an assessment situation. Comments translated immediately into action and direct real-time development of communication skills. Next best thing to live supervision.	1 – 2 – 3 X X
Wasyiko and Stickely (2003) UK	Theatre and pedagogy: using drama in mental health nurse education	Peer reviewed journal. Opinion article. Focus on use with mental health nursing education.	Links drama in education to humanistic and person-centred philosophy. Drama as a tool for development of empathy, reflection and the therapeutic relationship. Addresses stigma. Student engagement once involved in the process. Emotional intelligence development/regulation. Recognise lack of research evidence in this area. Keep group feeling safe yet challenged. High level of self-awareness and facilitation skills on the part of the tutor.	1 – 2 – 3 X X X
Nordstrom (2011) Sweden	Drama as a pedagogical tool for practicing death notification-experiences from the Swedish medical students.	Peer reviewed journal. No specific method provided – appeared interpretive. Ten undergraduate Medical Students. Semi structured interviews.	Useful pedagogical tool Realistic conditions reinforce student learning. Encourages self-reflection. Should be considered a new form of simulated learning Recommends support for students emotionally after the event. Body language – increased awareness on both speech and body language.	1 – 2 – 3 X X
Brett-McLean et al (2012) Canada	Exploring Professionalism in Undergraduate Medical and Dental Education through Forum Theatre	Peer reviewed journal. Commentary / discussion of lecturer experience. Dental and undergraduate medical students.	FT is an innovative method that can effectively foster a personally relevant, yet collaborative, discussion amongst students regarding professionalism. Expanded cognitive understanding and heightened awareness of tactic knowledge in applying professionalism. Highlights need for process-orientated enquiry.	1 – 2 – 3 X X
Themes: 1: Role Modelling Positive Power Relationships 2: The Learning Process. 3: Developing Communication Skills				

Included articles, their characteristics and contribution to the three themes – continued.

Author/ Country	Title	Source/Type/Method/Participants/Data Collection	Findings/Key Points	Link three descriptive themes
Love (2012) USA	Using theatre of the oppressed in nursing education	Peer reviewed journal. Reflective commentary. Adult nursing students.	Making people more aware of oppression and power relationships. Experience positive communication techniques for empowered thinking. Transform healthcare and improve care experience of vulnerable patients. Ethical thinking to improve clinical judgment and develop critical consciousness. Facilitator must be well versed. Concrete and looked for solutions rather than just analysed.	1 – 2 – 3 X X X
Himida et al (2019) UK	Dental students' perceptions of learning communication skills in a forum theatre-style teaching session on breaking bad news.	Peer reviewed journal. Mixed methods (though not explicit) Framework analysis of questionnaire text and descriptive statistics of Likert scale questions on confidence and ability in breaking bad news.	Further research is needed to assess educational benefits. Contributed to increased confidence in ability in breaking bad news. Problem based learning. Develops empathy and care - exposure to different viewpoints from peers. Provokes openness, questioning and reflection. Allows participants to bring own knowledge – empowers. Facilitator role 'making relevant to clinical reality'. Actor natural responses/quality. General communication skills – seeing how everyone will approach slightly differently.	1 – 2 – 3 X X
Jacob et al (2019) UK	Using forum theatre to teach communication skills within an undergraduate pharmacy curriculum: A qualitative evaluation of students' feedback.	Peer reviewed journal. No specific methods provided – appears to qualitative evaluation 468 student pharmacists. Online open-ended questions following workshop – thematically analysed.	Encouraged student reflection. Perceived as useful for developing communication skills. Feedback from facilitators/actors useful. Live, interactive nature of FT workshops enhanced learning. Role of facilitator. This is more of an evaluative study than primary research yet does yield some interesting findings worthy of discussion. Recommends future focus groups to further explore more comprehensive experiences of FT.	1 – 2 – 3 X X
Themes: 1: Role Modelling Positive Power Relationships 2: The Learning Process. 3: Developing Communication Skills				

Appendix 5: Participant Information Leaflets

Participant information leaflet – Phase 1

The Research Study

I am conducting a study exploring the experience and impact of Forum Theatre techniques for developing mental health nursing skills. You have been asked to be a part of this study because you are currently actively working as a pre or post reg mental health nurse/student. The aim of this research is to gather the opinions and experiences you have of Forum Theatre when used in training and to get an idea of the impact it has on you as a mental health nurse.

What does the study involve?

The study will include an interview which will last approximately 1 hour. The questions will be around what it's like to undergo training that with Forum Theatre techniques and you will be encouraged to speak freely about this topic. The interview will be recorded so the researcher can type up the discussions and review the results. The interview should take no longer than one hour. The researcher will ask if you would like to look through the copies of the interview to check it is a true reflection of what you said in the interview. Those interviewed will have the opportunity to see and discuss the results with the researcher individually or in a group setting at a later date.

Risks and Benefits

During the interview it may be possible that sensitive issues are discussed such as situations you find difficult in your practice. You are encouraged to take this into consideration before agreeing to take part.

What will happen to my personal information?

All identities and personal information will be kept confidential throughout the study. First names will be used during the recorded interviews and real names will not be used in the writing up of the study. All copies of the interviews and the recordings will be kept in a locked drawer or held within a password protected computer file. You will also have the opportunity to look through the transcripts should you wish to ensure no information is identifiable. If this study gets published into a journal article, all volunteers will be notified beforehand. During the writing up of the study, the researcher may need to discuss the findings with their colleagues. This is to check the results are valid and again that no identifiable information is visible. The researchers are also bound by confidentiality rules within their place of work. The Berkshire

Healthcare NHS Foundation Trust Research and Development Team may need to access the data to comply with ethical approvals.

Do I have to take part?

You do not need to volunteer to participate unless you want to. You are also free to withdraw at any time and do not need to give an explanation if you do not wish to continue. If you choose to withdraw this will not affect your ability to continue taking part in the support group or future support groups.

Who is organising and funding the research?

The researcher is conducting this research through the University of West London and has a named supervisor who is overseeing the study. The study has also been approved by Berkshire Healthcare NHS Trust and the University Ethics Department.

Contact for further information

If you would like more information about the study you can contact either myself or the research supervisor on the contacts below.

Researcher
Reuben Pearce
Tel: 07545251421
Email: Reuben.Pearce@uwl.ac.uk

Supervisor
Dr Rowan Myron
Tel: 020 8209 4110
Email: rowan.myron@uwl.ac.uk

Thank you very much for your time

Participant information leaflet – Phase 2

The Research Study

I am conducting a study exploring the experience and impact of Forum Theatre techniques for developing mental health nursing skills. You have been asked to be a part of this study because you are currently actively working as a pre or post reg mental health nurse/student. The aim of this research is to gather the opinions and experiences you have of Forum Theatre when used in training and to get an idea of the impact it has on you as a mental health nurse.

What does the study involve?

The study will involve a questionnaire called the Jefferson Scale of Empathy that you will complete before and after a Forum Theatre workshop on developing nursing practice skills. The questionnaire will take approximately fifteen minutes to complete. There are twenty questions on the questionnaire.

Risks and Benefits

It is not anticipated that there are any risks to completing the questionnaire, but you are encouraged be sure that you want to take part and ask questions should you have any queries.

What will happen to my personal information?

There is no personal identifiable information recorded on the questionnaire and all information will be kept confidential throughout the study. All copies of the questionnaires will be kept in a locked drawer. During the writing up of the study, the researcher may need to discuss the findings with their colleagues. This is to check the results are valid and again that no identifiable information is visible. You are welcome to request details of the results of the questionnaire at any stage should you wish during the period of the study. The researchers are also bound by confidentiality rules within their place of work. The Berkshire Healthcare NHS Foundation Trust Research and Development Team may need to access the data to comply with ethical approvals.

Do I have to take part?

You do not need to volunteer to participate unless you want to. You are also free to withdraw at any time and do not need to give an explanation if you do not wish to continue. If you choose to withdraw this will not affect your ability to continue taking part in the support group or future support groups.

Who is organising and funding the research?

The researcher is conducting this research through the University of West London and has a named supervisor who is overseeing the study. The study has also been approved by Berkshire Healthcare NHS Trust and the University Ethics Department.

Contact for further information

If you would like more information about the study you can contact either myself or the research supervisor on the contacts below.

Researcher
Reuben Pearce
Tel: 07545251421
Email: Reuben.Pearce@uwl.ac.uk

Supervisor
Dr Rowan Myron
Tel: 020 8209 4110
Email: rowan.myron@uwl.ac.uk

Thank you very much for your time

Appendix 6: Consent Forms for Phase 1 and Phase 2

UNIVERSITY OF WEST LONDON

Research Consent Form Phase 1

Title of Project: Exploring the experience and impact of Forum Theatre techniques for developing mental health nursing skills – A mixed methods research project

Lead Researcher: Reuben Pearce

Please sign your initials in the boxes to show you consent to each point:

I confirm that I have read and understand the information sheet dated xxxxxx xxxx for the above study and have had the opportunity to ask questions. ☐

I understand that my interview (if interviewed) will be recorded. ☐

I understand my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐

I understand that the results of the study may be shared with the researchers' colleagues, as a way of reviewing the findings. I understand that the data from the interviews may be kept confidentially for up to 5 years before being destroyed. ☐

I agree to take part in the above study. ☐

Name of participant	Date	Signature
Name of person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

Research Consent Form phase 2

Title of Project: Exploring the experience and impact of Forum Theatre techniques for developing mental health nursing skills – A mixed methods research project

Lead Researcher: Reuben Pearce

Please sign your initials in the boxes to show you consent to each point:

I confirm that I have read and understand the information sheet dated xxxxxx xxxx for the above study and have had the opportunity to ask questions. ☐

I understand my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐

I understand that the results of the study may be shared with the researchers' colleagues, as a way of reviewing the findings. I understand that the data from the questionaire may be kept confidentially for up to 5 years before being destroyed. ☐

I agree to take part in the above study. ☐

Name of participant	Date	Signature
Name of person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

Appendix 7: Interview Questions Template

Semi-Structured Interview Schedule

Initial Questions	Main Questions	Additional Questions	Clarifying Questions
Please tell me a little about yourself.		Age? How many years clinical experience? What further CPD have you done since qualifying?	
Tell me about your clinical role.		What are the challenges of the role? What are the challenges to you personally?	Can you tell me some more about that?
How long have you been working in your current clinical role?		Did you need any special training/qualification further to what you had already completed for this role?	Can you tell me more about that?
	How are you finding the experience of taking part in training that uses Forum Theatre?	What is good or bad about it?	Can you tell me more about that?
	Can you tell me about what you feel you have you learnt by attending?	What have you taken away with you?	Can you give me an example of this?

Appendix 8: License to use Jefferson Scale of Empathy

From: Jefferson Scale of Empathy <empathy@jefferson.edu>
Sent: 04 June 2019 18:43
To: Reuben Pearce <Reuben.Pearce@uwl.ac.uk>
Subject: RE: Jefferson Empathy Scale License

Hi Reuben,

I received a confirmation e-mail from your advisor. Thank you.

With your agreement to all conditions stated in our previous emails, you have our permission to make 300 copies of the JSE –HP version for the single not-for-profit study that you described. I have attached a copy of the scale, the User's Guide and the scoring algorithm. In addition to instructions for administering the JSE, the User Guide gives a detailed account of the creation of the JSE, its evolution and validity studies, etc., written by Dr. Hojat. It also contains an extensive bibliography. Please note that you are welcome to take advantage of the optional fields in case you'd like to track any additional information.

We wish you luck with your research! Please keep us informed of your progress.

Thanks,
Shira

Appendix 9: Ethical Approval

Ethical Approval 1 (Qualitative phase)

Mr Reuben Pearce
Student No: 10141364

12 April 2017

College of Nursing,
Midwifery & Healthcare
Research Ethics Panel
Paragon House
Boston Manor Road
Brentford TW8 9GA
Tel: +44 (0)20 8209
4110/4145
email:
cnmh.ethics@uwl.ac.uk

Dear Reuben

Re: Application for Ethical Approval No. UWL/REC/CNMH-00135

Thank you for sending in your application for approval. The Committee has considered this and approved the research.

If the research does not progress, or if you make any changes to your research proposal or methodology can you please inform the Committee in writing as this may entail the need for additional review.

It is your responsibility, as the principal investigator, to submit a report on the progress/completion of the research twelve months from the date of this letter. The Committee wish you well with your research and look forward to your report.

Yours sincerely

Heather Loveday

Professor Heather Loveday
Director of Research
Richard Wells Research Centre
Joanna Briggs Institute Collaborating Centre
College of Nursing, Midwifery and Healthcare
UNIVERSITY OF WEST LONDON
Paragon House
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Ethical Approval 2 (Quantitative phase)

Reuben Pearce
26th February 2019

Dear Reuben

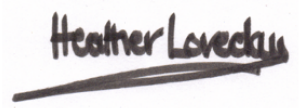
Re: Application for Ethical Approval No. UWL/REC/CNMH-

Thank you for sending in your application for approval. The Panel has considered this and approved the research without major amendment.

If the research does not progress, or if you make any changes to your research proposal or methodology can you please inform the Panel in writing as this may entail the need for additional review. It is your responsibility, as the principal investigator, to submit a report on the progress/completion of the research twelve months from the date of this letter. Please find attached a blank report form to be completed by 01 January 2020.

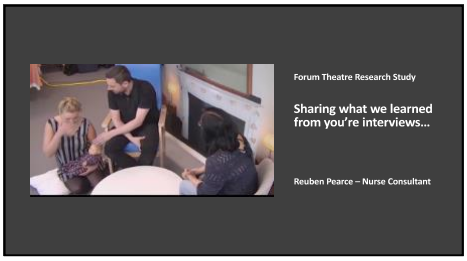
The Panel wish you well with your research and look forward to your report.

Yours sincerely



Professor Heather Loveday
Director of Research
Chair, College Research Ethics Panel

Appendix 10: Focus Group Presentation



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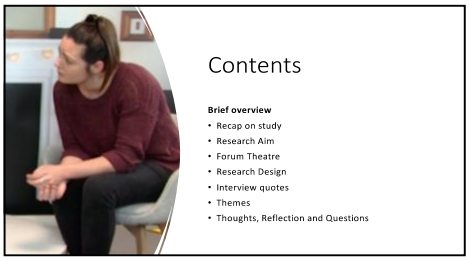

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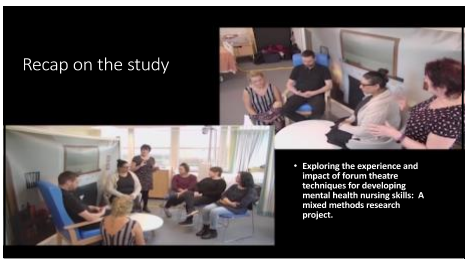

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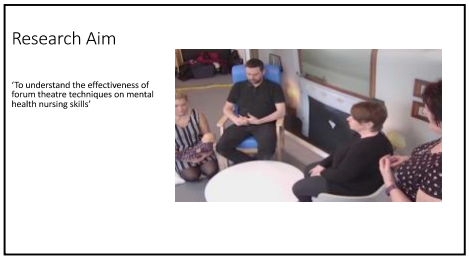

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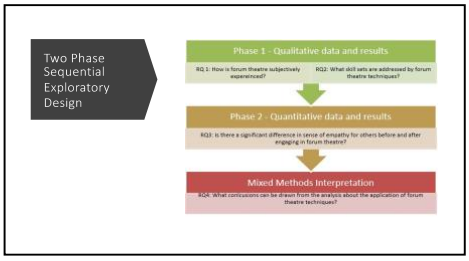

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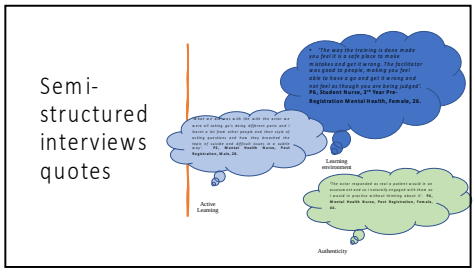
Semi-structured interviews quotes
"The way the training is done made you feel it is a safe place to make mistakes and get it wrong. The facilitator was good to people, making you feel able to have a go and get it wrong and not feel as though you are being judged". P6, Student Nurse, 3rd Year Pre-Registration Mental Health, Female, 26.
"I feel as if I want to hit the ends the sense we were all taking go's doing different parts and I learnt a lot from other people and their style of asking questions and how they bounced the ideas of the other and different issues in a wide way." P2, Mental Health Nurse, Post Registration, Male, 26.
Learning environment
Active Learning
"The actor responded as real a patient would in an assessment and as I recently engaged with them as I would in practice without thinking about it". P6, Mental Health Nurse, Post Registration, Female, 26.
Authenticity

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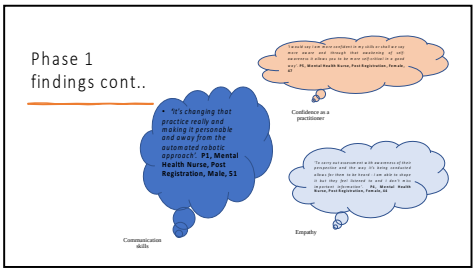
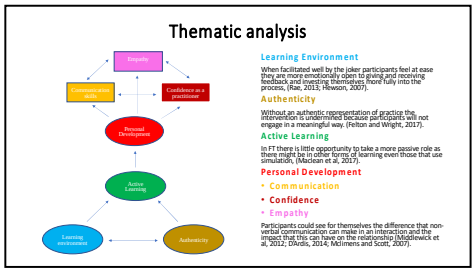

Phase 1 findings cont..
"It's changing that practice really and making it personable and away from the automated robotic approach". P1, Mental Health Nurse, Post Registration, Male, 51
"I would say I am more confident in my skills in what we may never aware and through that awakening of self awareness it allows you to be more self-critical in a good way". P1, Mental Health Nurse, Post Registration, Female, 51
Confidence as a practitioner
"To carry out assessment with awareness of their perspective and the way it's being conducted allows for them to be heard. I am able to shape it but they feel listened to and I don't wise in practice information". P6, Mental Health Nurse, Post Registration, Female, 26
Empathy
Communication skills

8


Thematic analysis
Empathy
Communication skills
Confidence as a practitioner
Personal Development
Active Learning
Learning environment
Authenticity
Learning Environment
When facilitated well by the joker participants feel at ease they are more emotionally open to giving and receiving feedback and investing themselves more fully into the process, (Rae, 2013; Hewson, 2007).
Authenticity
Without an authentic representation of practice the intervention is undermined because participants will not engage in a meaningful way. (Felton and Wright, 2017).
Active Learning
In FT there is little opportunity to take a more passive role as there might be in other forms of learning even those that use simulation, (Maclean et al, 2017).
Personal Development
• Communication
• Confidence
• Empathy
Participants could see for themselves the difference that non-verbal communication can make in an interaction and the impact that this can have on the relationship (Middlewick et al, 2012; D'Ardis, 2014; McImmens and Scott, 2007).

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Thoughts, reflections and questions?

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References
Reed, A. (2008) Theatre of the Oppressed. (3rd ed). London: Pluto.
Wickstrom, S., Chambers, M., Barker, F., Thomas, B. and Watts, P. (2014) Measuring the evidence: reviewing the literature of the measurement of therapeutic engagement in acute mental health inpatient wards. International Journal of Mental Health Nursing, 23(5), pp 312-326.
Rogers, C. (1986) Carl Rogers on the development of the person-centered approach. Person-Centered Review, 1(5), 257-259.

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