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RESEARCH ARTICLE



Stand-up-comedy inspired experiential learning for connecting emotions and cognitions in healthcare education: A pilot study

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ABSTRACT



In stand-up comedy, a single actor establishes an intimate relationship with the audience and discusses out loud emotional issues regarding taboo subjects. The ‘stand-up design of instruction’ (STUDI) uses similar techniques in a three minutes video to help learners connect emotional and cognitive experiences of mental health problems in six steps. The present article discusses a pilot experiment using the STUDI pedagogical model. The results showed that learners developed a positive appreciation of the training, a better emotional and cognitive understanding of the experience of mental health problems, the ability to exercise subjective and objective analysis through engaging in dialogue with other students, and increased motivation and memory-anchoring. In addition to other methods, such as simulated patients or peer teaching, STUDI can provide a simple and inexpensive pedagogical alternative using standing techniques to address large groups of students and short-circuit the barriers between emotions and cognitions.

KEYWORDS

Comedy; medical education; mental health; stand-up

Introduction

One of the main challenges of medical education is to develop partly antagonistic skills: on one hand, scientific knowledge and attitude, and on the other, relational skills and emotional understanding. Scientific knowledge requires a detached, objective, generalisable attitude, independent of the person or situation. In contrast, emotional and relational skills are unique to the person and situation and require close identification with others. The construct of cognitive empathy integrates these cognitive and affective dimensions of medical communication: recognising and understanding the experience of the other, articulating and communicating it, and then taking appropriate action (Mercer & Reynolds, 2002). Empathy enhances the ability to provide effective care by

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allowing the patient to report more symptoms, increase diagnostic accuracy, integrate more information about the disease, increase patient information, participation, compliance, and empowerment, and decrease patient stress (Neumann et al., 2009). However, medical studies could contribute to the erosion of students' capacity for empathy due to stress, ill-prepared first contact with distressed patients, and even medical studies themselves (Neumann et al., 2011). In other words, training courses should offer teaching devices that enable clinicians to understand not only the diseases but also the patients' experience (illness) to improve patient participation in the treatment.

From a pedagogical point of view, the management of one's own emotions and personal representations concerning health problems is a central dimension of learning for the development of relational skills. Experiences from personal life and clinical practice constitute the frames of reference for each student. When training offers new information that contrasts with the knowledge acquired through past experiences, an internal imbalance, called cognitive conflict, occurs (Piaget, 1973, 2002). For learning to take place, the teaching system must include methods to help students overcome this conflict and appropriate the new information. It is then a question of encouraging the processes of accommodation and assimilation, which are necessary to overcome this imbalance and to develop new skills. The zone of proximal development and collaborative learning (Vygotsky & Cole, 1978) are pedagogical resources for students to construct their own knowledge (Dewey, 1986). STUDI allows students to have quality emotional experiences (video), to interact with others (students and teachers), to confront initial representations and to construct new ones. Experiential learning integrates cognitive and social-emotional factors (Kolb, 1981, 2014). The model includes a four-step cycle that proposes a concrete experience as the basis for observation and reflection. The observations made by the learner are used to develop a conceptual understanding from which new implications for action can be derived. These new implications guide action and new experiences. These steps require specific skills of personal engagement, observation and reflection, as well as the ability to create new models that are consistent with observations and to make decisions to solve problems. The learner is involved to varying degrees on a continuum as an actor or observer and a continuum from specific personal involvement to general analytical detachment. Each mode of learning is associated with a major characteristic of personal development: knowledge development through concrete experience is characterised by an increase in competence in affective complexity; the development in reflective observation is characterised by a greater competence in perceptual complexity.

Bedside teaching has traditionally been the most common way to impart medical knowledge experientially. However, this practice can only be done individually or in small groups and only allows confrontation with a limited number of health problems. Moreover, the participation of vulnerable persons in teaching raises major and insurmountable ethical problems; thus, this practice has been abandoned in lecture hall teaching. Experiential learning may involve students for physical examination or practising technical tasks among peers, which is not devoid of ethical risks and less appropriate for exploring intimate feelings (Grace et al., 2017). The simulated patient may be an interesting alternative, but it is expensive and technically difficult to implement on a large scale and generally focuses on the disease rather than the sick person. There are also effective training courses that focus on communication skills, such as breaking bad news (Berney et al., 2017), but which may sometimes separate the learning of

interpersonal skills from knowledge about a specific disorder. There is, therefore, an unmet need for simple educational methods that combine knowledge about the disease with an emotional understanding of the person's experience.

STUDI

STUDI is an innovative educational tool that provides an experiential and reflective environment for future clinicians, centred on the patient experience. Based on the stand-up comedy format in which a comedian addresses his audience directly through a humorous monologue. A single actor, without set, costume, or props, speaks directly to the audience in a familiar manner (Brodie, 2008) in a video; they express aloud feelings about social realities that are usually unspoken (Koziski, 1984). In this article, they express patients' feelings and lived experiences. Viewing the video by the audience constitutes an experience for the students who are taken into the narrative presented and experience the emotions reported by the actor. Following this stage, analyses of the lived experience are conducted in groups in the course, soliciting the students to observe/reflect on their feelings concerning the health problem narrated in the first person by the actor. These first two stages involve the students and encourage processes of identification with the patients. These collective analyses (complemented by theoretical resources) are a cornerstone for transforming the students' experiences during the viewing into real new knowledge about illnesses and the patient experience. These conversational spaces necessary for learning have been described in various studies (Baker et al., 2005; Nguyen et al., 2022, 2016). The study aims to investigate the feasibility of a pedagogical method using stand-up comedy techniques in videos and evaluate its effect on the emotional and cognitive understanding of mental health problems in students in different settings.

Methods

Teaching method

To give students a real-life experience of mental health issues, they view a three-minute video that uses stand-up comedy techniques such as challenge and betrayal (McCarron & Savin-Baden, 2008). Challenge is a direct address to the audience, which increases identification with the subject. Betrayal involves engaging the audience in intimate complicity and then betraying them by linking this positive identification to negative consequences. The three minutes video is the first and main resource of the device. A single person, without props, addresses the spectator in the second person, 'you' to present the problem to be solved by recounting a fictional lived experience in the second person ('you've just left your house, what a joy to be back in the sun'). The second person allows the students to be directly engaged in the form of intimacy to activate their previous experiences and understand the problem (challenge). The scenario is constructed to favour an initial identification with the situation to provoke, later on, a discordance to understand the lived experience of the problem (betrayal). It is inspired by real situations, which are worked as fiction to meet the pedagogical objectives. The scenario does not directly convey knowledge, but stages a problem that requires specific knowledge to solve. In the video, the performer focuses in a short time on all the elements

of the mental health problem to be analysed. For example, the video on specific personality disorders will make students feel the person's experience, the symptom of the disorder, and ways to motivate change.

Teaching process

STUDI consists of six steps which are summarised in Table 1.

As an example, the teaching of early psychosis (video: <https://youtu.be/nuExdeu1KpM>) has been described in detail in a previous article (Bonsack et al., 2020).

Evaluation of teaching

The study aimed to develop and test a new pedagogical method and to gain insights into its feasibility and students' perceptions through a prospective post-intervention questionnaire survey. The evaluation focused on the acceptance of the pedagogical format and the students' appreciation of the skills fostered by experiential education: understanding others' experiences, dealing with uncertainty, and developing internal motivation (Verduin et al., 2013). The survey included general questions on the perceived quality of the course and specific questions on the teaching method, including appreciation of the video format, understanding of the patient's experience, increased familiarity with mental health problems or impact on retention of information.

Target populations

A convenience sample of 125 students from four courses given by two of the authors (C. B. and J.F.) across three universities were evaluated: pre-graduate training in psychiatry. The following table (Table 2) describes the subgroups in our sample and which groups of participants were exposed to which video.

Table 1. STUDI's six steps of learning.

Process	Instructional actions	Learning activities
Step 1	To introduce pedagogical objectives (theories, skills)	To understand the meaning and goals of the device
Step 2	To show the STUDI video to the students	To watch, be carried away by the narration, experience the patient's experience
Step 3	To invite the students to discuss in small groups their experiences during the viewing	To explain the experiences/knowledge related to the video (situations, emotions, thoughts related to past experiences)
Step 4	To facilitate a collective exchange based on the students' prior knowledge (professional, personal experiential, scientific knowledge)	To present prior knowledge To discover the collective knowledge
Step 5	To present the theoretical knowledge concerning the health problem and the patient's experience. The teacher can prepare his/her own answers or use external references or articles.	To acquire theoretical resources for the development of new academic knowledge
Step 6	To conduct a discussion on the possible applications of this new knowledge to clinical practice	To develop concrete ideas for the transfer of knowledge into clinical practice

Table 2. Settings of pilot teaching experiences.

Participants	Location	Theme
9 future psychiatrists in training	University of Aix-Marseille	First episode of psychosis
12 diverse professionals in mental health	Cognitive behavioural therapy psychotherapy continuous training at University of Geneva	First episode of psychosis
54 pre-graduate training in medicine	University of Lausanne	Difficult-to-engage patient with schizophrenia
50 experienced general practitioners	Continuing education for general practitioners, Société Vaudoise de Médecine and University of Lausanne	Suicide prevention

Evaluation

The evaluation of programme outcomes was conducted by the Medical Education Department of the University Hospital of Lausanne and the University of Lausanne and was based on participants' responses to 14 closed-ended questions. These 14 questions included descriptive statements about students' understanding of the experience of mental health problems, whether the video influenced their stigmatisation of mental disorders, and the retention of the knowledge acquired. Participants reported their level of agreement with each ('yes', 'slightly yes', 'slightly no', 'no opinion', or 'no answer'). Frequencies of responses were calculated as a percentage and presented in tables. Further, the students could provide free written comments regarding their opinions on using the video format, the strong points of the overall teaching approach, and areas of the teaching that could be improved. The teaching unit provided the free comments anonymously with one line per student. The comments were written by the students in the form of short sentences or keywords. They were analysed according to the principles of qualitative content analysis (Graneheim & Lundman, 2004). The units of meaning were extracted as they were without rephrasing or interpreting latent content. The classification by themes was partly deductive for the themes of experiencing, understanding of the experience, and emotional understanding, and inductive for the other content from the comments. Credibility is supported by showing representative quotations from written units of meaning in each theme category (Graneheim & Lundman, 2004). Students received specific oral information about the aims of the present evaluation at the beginning of the course and participated voluntarily and anonymously in the survey. No personal data concerning their health were collected. They did not receive credits to participate in the study. The project was submitted to the local ethical committee (CER-VD Req-2022-01142) which stated that the project falls within the Swiss law for Research on Human Subjects (LRH) and, therefore, does not require authorisation.

Teaching themes

Approximately 20 videos¹ were produced (in French) for topics related to the fields of social psychiatry (e.g. stigmatisation, approach to homeless people with mental-health problems, individual support for employment, deciding whether to disclose a mental-health problem) and general psychiatry and psychotherapy (e.g. various personality disorders, suicide, experiencing one's first psychotic episode, experiencing psychiatric emergencies in the home, and difficult-to-engage patients). An example of teaching early psychosis has been detailed in a previous article (Bonsack et al., 2020).

Results

Assessment of the teaching approach

The model was tested and improved in small groups, then experimented with and evaluated in real life with students in training in different contexts and with different trainers. During this experimentation, the format of the videos remained the same, but certain animation elements were tested and/or modified according to the students' feedback. The results of the assessments in the different settings were combined into a single sample. Comments referring to a specific setting are indicated in the text.

Closed questionnaire

The students' overall perception of the teaching was positive (no question received > 20% disapproval), as shown in Table 3. More than 90% of the participants found that the training was well adapted to their prior knowledge, they were able to analyse the proposed situation using their theoretical knowledge, they appreciated the format of the video, and better understand the lived experience of people with mental health problems, which increases their openness to mental health problems. More than 80% of the participants answered positively or rather positively to all questions.

Table 3. Results of the closed-ended questionnaire (n = 125).

	Yes (%)	Rather yes (%)	Rather no (%)	No (%)	No opinion (%)	Without answer (%)
1. The objectives of the teaching were presented	78 (62.4)	33 (26.4)	7 (5.6)	2 (1.6)	5 (4.0)	0 (0.0)
2. The teaching was well structured	69 (55.2)	34 (27.2)	15 (12.0)	4 (3.2)	2 (1.6)	1 (0.8)
3. The course was well adapted to your prior knowledge	86 (68.8)	32 (25.6)	2 (1.6)	1 (0.8)	4 (3.2)	0 (0.0)
4. The questions related to the video guided your learning	68 (54.4)	36 (28.8)	11 (8.8)	4 (3.2)	4 (3.2)	2 (1.6)
5. You were able to analyse the proposed situation using your theoretical knowledge	73 (58.4)	45 (36.0)	5 (4.0)	1 (0.8)	1 (0.8)	0 (0.0)
6. You were able to analyse the proposed situation from your own life experience	72 (57.6)	28 (22.4)	15 (12.0)	4 (3.2)	6 (4.8)	0 (0.0)
7. Overall, you appreciated the format of the video	91 (72.8)	26 (20.8)	4 (3.2)	2 (1.6)	2 (1.6)	0 (0.0)
8. The teaching allowed you to deepen your prior knowledge	57 (45.6)	48 (38.4)	9 (7.2)	5 (4.0)	2 (1.6)	4 (3.2)
9. The teaching allowed you to better understand the lived experience of people with mental health problems	77 (61.6)	45 (36.0)	2 (1.6)	0 (0.0)	0 (0.0)	1 (0.8)
10. The teaching allowed you to increase your openness to mental health issues	69 (55.2)	38 (30.4)	6 (4.8)	4 (3.2)	7 (5.6)	1 (0.8)
11. Your thinking was stimulated	80 (64.0)	29 (23.2)	6 (4.8)	6 (4.8)	3 (2.4)	1 (0.8)
12. The supervision was adequate	81 (64.8)	32 (25.6)	5 (4.0)	2 (1.6)	4 (3.2)	1 (0.8)
13. The teacher was open to questions or expressions of opinion from students	108 (86.4)	11 (8.8)	0 (0.0)	0 (0.0)	3 (2.4)	3 (2.4)
14. Overall, you appreciated this teaching	74 (59.2)	37 (29.6)	5 (4.0)	6 (4.8)	2 (1.6)	1 (0.8)

Free comments

Fifty of the 125 learners (40%) left a free comment regarding the video-based format, while 32 (26%) and 36 (29%) learners commented on the strengths and weaknesses, respectively, of the teaching approach. All comments were segmented by units of meaning and then grouped by theme. The credibility of the qualitative analysis will be supported by literal excerpts of the written comments, professionally translated from French to English, for the present article. Some comments did not directly address the pedagogical method. Those comments comprised positive general evaluations of the course (14) and of the teacher (two). Others criticised mixing other content than STUDI pedagogical experience into the same course (25 comments about the session of pre-graduate medical teaching).

General comments

Participants were informed at the beginning of the course about the pilot experiment and the post-course assessment. They generally appreciated the video format, feeling that it was a pedagogical innovation that induces experiencing, surprises, maintains attention, and stimulates reflection. Video activated both cognitive and affective reactions (32 comments).

Example comments: 'Original, innovative approach; makes it easier to maintain attention and, therefore, learn and reflect on the topics covered'. 'More thought stimulating than a traditional course . . . You come out with an experience and not 50 slides to learn by heart'.

The information is delivered quickly and requires good sound quality and a lot of attention from the learners. Most learners appreciate the brevity of the problem presentation, but some would like a longer experience (4 comments) or a repetition of the video (1 comment). On the other hand, learners feel that a second viewing after the theoretical part is unnecessary if it has already been done (6 comments). Therefore, we did not maintain the practice of second viewing after the first session. Most learners appreciate the interactivity and the stimulation of the exchange, especially between the participants rather than with the teacher (12 comments). Two comments preferred a course without discussion. The first group of students (Marseille) suggested a moment of discussion in small groups of between two or three neighbouring students in the audience, which we continued with the following courses.

Example comments: '[The teaching format was] very encouraging of exchanges and dialogue between learners'; '[I enjoyed] forming small groups [. . .], which allowed us to discuss more with each other than with the teacher'.

Meanwhile, 22 comments express the students' feelings about sharing the patients' emotional and cognitive experiences from the inside, even when it concerned psychosis. Students saw this as a major strength of the teaching. Sixteen comments reported that identifying with the patient helps to understand the experience from the patient's perspective and anchors knowledge. Such comments are in line with the main objectives of teaching.

Example comments: '[The teaching format] allowed us to understand these patients' lives, and not just acquire theoretical information'; 'Small insignificant details can play a key role in the life of an unstable patient'.

Among these comments, markers of experiential learning appear: 'Verbalizing emotions allows us to take distance and see the problem from a new angle'; 'The fact of being a witness, pushes us to find solutions and do something'. Three comments pointed to the difficulty, discomfort, and even confusion associated with identifying with a person with a mental health problem; meanwhile, three participants said they would have preferred direct testimony from a patient. Finally, three participants said they would have liked to receive a theoretical explanation before the video.

Discussion

Our study addresses an unmet educational need in health care to understand the links between the person's experience and her/his disease. This need is particularly important in mental health and partly determines the effectiveness, satisfaction, and quality of care (Mercer & Reynolds, 2002). Medicine, in particular the mental health field, needs methods to teach not only the 'sick object' (disease) but also the 'sick subject' (illness). There are few pedagogical methods to address the latter in the conventional auditorium. The pilot experience discussed in this study shows that the STUDI teaching method is feasible, acceptable, appreciated by most students, and usable in various settings.

Moreover, the results show that it is possible to stimulate cognitive and emotional understanding of a mental health problem through a simple and inexpensive experiential learning method inspired by stand-up comedy. The experience consists of being challenged by a character in a video that appeals to self-experiences and emotions by expressing the usually unspoken through techniques derived from stand-up comedy. The script encourages initial identification through seemingly positive elements and direct interpellation in 'you' (challenge), then betrays the learner by introducing the discordances associated with the mental health problem (betrayal). The quantitative and qualitative results show that the strength of the teaching model lies in its experiential dimensions for the learner, through (1) stimulating active learner participation, (2) identification with a fictional character suffering from a mental health problem, (3) activation of prior affective and cognitive knowledge, and (4) reflection and naming of the lived experience through conversation. This process places STUDI in the initial stages of experiential learning. Knowledge is created through the transformation of experience in a cycle of concrete experience, reflective observation, abstract conceptualisation, and active experimentation (Kolb, 2014). The originality consists in the fact that the video essentially triggers an inner experience rather than a practical one, followed by an experiential process of learners constructing meaning from their collective experiences through conversation (Baker et al., 2005). The pedagogical tool represents an innovative model for teaching psychiatry that combines complementary approaches focused on experience, reflection, acquisition of theoretical knowledge, and transfer to practice (Baker et al., 2005; Kolb, 2014; Merrill, 2002). The pedagogical format mobilises learners' internal motivation and anchors knowledge of lived experiences through self-identification. It encourages learners to question their relationships with others, their ethics, and their modes of communication and to attempt to solve problems autonomously by applying their knowledge (Verduin et al., 2013). Through the characters presented in the stand-up comedy, the learners, as the audience, can develop some

understanding of what it means to be discriminated against because of mental-health issues (Koziski, 1984).

Students appreciated the video format which captured their attention and stimulated their participation. The experience is perceived as internal through identification with the character and external through the strangeness of the other's life experience. The results show that the pedagogical model enabled them to actively acquire knowledge, to anchor the learning in memory, and to better share part of the human experience of the sick person. Reflection, peer discussion, and analysis of the situation enabled them to name the emotions and knowledge that they experienced, while relating and distinguishing them from their own past experiences. Thus, the instructional format promotes several dimensions of empathy (Neumann et al., 2011): empathetic identification with others, reflection on one's own emotions, analysis and explicit naming of these emotions, and, finally, verbalisation of one's emotions through group discussions. First, directly questioned in 'you' in an initially attractive situation, the student is pushed to sympathetically identify with the character presented in the video. This identification reminds the student of memories close to the experience the character portrays. The reflection and analysis by students allow the naming of the emotions they experienced in an echo of the character. The discussion then allows students to verbalise their own emotions and distinguish them from those of the character, while gaining a deeper empathic understanding of their own life experiences.

Using a stand-up format in teaching affords the linking of affective and cognitive aspects (McCarron & Savin-Baden, 2008). Unlike conventional academic teaching, which starts with knowledge acquisition and then moves into practice, teaching begins with an experience similar to real life but in a condensed, accelerated way and focuses on a specific health problem. Three minutes of video condenses enough information for learners to collectively find the key theoretical elements they will discuss later.

Compared to classical frontal teaching, this pedagogical method allows for a sense of intimacy as well as student participation that is normally only possible in small groups. He introduces the subject by first anchoring it in the learner's personal experiences and prior knowledge. In this way, he approaches complex and intimate topics inductively and then integrates the emotional and cognitive dimensions into the process of reflection and analysis. Therefore, the proposed pedagogical format shows that small-group teaching is not a necessary condition for developing students' empathy and understanding of others' experiences; on the contrary, a large group may allow more freedom of expression by providing greater anonymity for students. This may result in the voicing of multiple perspectives and analyses, thereby helping learners acquire a multifaceted global understanding of an experience (McCarron & Savin-Baden, 2008). However, in contrast to other pedagogical methods inspired by stand-up comedy, the teacher does not require live acting skills, as the stand-up performance is presented through a video.

Compared to other experiential methods in medicine, such as bedside teaching, simulated patients, or peer teaching, STUDI overcomes some ethical and practical issues. Compared to teaching with real patients, the teaching method does not expose real people in vulnerable situations, which is ethically possible only with great care and exclusively in one-to-one encounters or very small groups. Moreover, teaching with real patients rarely addresses intimate feelings or emotions for the same ethical reasons. Finally, real patients cannot confront students with every disease or symptom.

Compared to teaching with real or simulated patients, STUDI shortens the exchange of experiences to a few minutes: It directly addresses the emotions and experiences of the learners. In this way, the essence of the educational content, which would take much more time with a real or simulated patient, is condensed into a few minutes. They are not confronted with another person, but with themselves, which could trigger unpleasant or traumatic personal memories. There is also no encounter with a real person as in peer teaching, and the latter could have a stronger destigmatising effect. Finally, unlike other methods that focus on doctor-patient communication, STUDI does not train communication but directly addresses the inner experience of the learner by bypassing communication barriers.

Limitations

The author of the method (C.B.) created 14 of the 20 videos, and the teaching was provided by approximately ten different teachers under C.B. and J.F. direction. To generalise the method, it will be necessary to diversify the creators of the videos and increase the number of teachers. Additionally, this study did not assess the learning results in terms of skills or knowledge acquisition.

Identifying the sick person confused some learners: 'we don't know who is [the caregiver, the student] who [or the sick person]'. Students' discomfort was especially high for strange and stigmatised experiences (e.g. psychosis), and when learners had first-hand experience of the subject (e.g. the suicide of a relative). In small groups, strong identification with the situation can lead to intimate revelations; facilitators must deal with such occurrences. Such a case occurred, for example, during the teaching on burnout for health professionals.

Nevertheless, the fictional format induced a certain detachment for the learners, which allowed them to discuss their lived experiences spontaneously as if they were about other people. In this way, STUDI may develop empathy (resonating with the experiences of others while remaining oneself), train analysis of knowledge acquired through empathy (describing the experiences of others through one's own emotions), and helps improve empathic knowledge (explicit formulation of the experiences of others).

Future research

The main challenge is to perform an in-depth pedagogical analysis on this model and make it transferable and generalisable; in particular, script construction, the direction of actors, and filming are key focus areas for the conception of new videos. Meanwhile, teachers need to familiarise themselves with the use of pedagogical material in courses and animation techniques. An online training course is currently in development. The model could also be expanded to medical issues other than mental health, which could assist in efforts to improve empathy and caregiver-patient relationships. STUDI can also be used more widely, for example, videos have been developed to address issues around inter-professional collaboration or to raise awareness of the importance of resuscitation training.

The results of the teaching should be assessed in various dimensions, for example, in terms of the acquisition of knowledge and the ability to discuss ethical issues and cope with new problems independently. In addition, the impact of teaching on students'

empathy should be specifically examined, especially with regard to disorders that are difficult to understand or stigmatised, such as psychosis.

Conclusions

Health education needs simple and effective experiential teaching methods to develop integrated emotional and cognitive skills. Direct encounter with the sick person is ethically and practically problematic and requires other experiential alternatives. Among other methods, such as simulated patients or peer teaching, the proposed pedagogical method can be a simple and cost-effective alternative that uses impromptu techniques to address large groups of students and short-circuit the barriers between emotions and cognitions.

Note

1. https://youtube.com/playlist?list=PLkqYgHWskYbqIP7sVfd_reAyOYKK0Exu9

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