Using Sociodrama to Foster Cultural Humility among Faculty and Students in the Academic Medical Center

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Abstract: Cultural humility and cultural safety offer the potential to go beyond what is possible with cultural competence to reduce unconscious bias and discrimination in medicine and to foster diversity and inclusion. Cultural humility moves the focus from one on content and the provider as the repository of knowledge to an emphasis on the process of learning and communication between the provider and the patient, thereby modifying the power dynamic within the provider-patient relationship and creating an openness for patient expression and sharing. By creating a space of cultural safety, the provider engages with the patient from a value-neutral perspective such that the patient is neither blamed nor discounted. Cultural humility can be fostered in the academic medical center by using sociodramatic techniques to explore scenarios that are relevant to faculty, students, and staff. Successful use of this technique can help to clarify conflicts in intergroup conflicts, foster critical questioning, build an awareness of how individuals may feel alienated and dislocated, help to develop empathy, and provide an opportunity for individuals to explore possible responses to a variety of situations.

Keywords: *Cultural humility; cultural competence; cultural safety; cultural sensitivity; diversity; medical education; sociodrama..*

How to cite: Loue, S. (2018). Using Sociodrama to Foster Cultural Humility among Faculty and Students in the Academic Medical Center. *Revista Romaneasca pentru Educatie Multidimensionala*, 10(2), 45-57. <https://doi.org/10.18662/rrem/45>

1. Promoting Diversity and Inclusion in Medical Education

Leaders in American medical education have recognized repeatedly that racism and implicit bias affect clinical practice and ultimately contribute to existing health inequities. This state of affairs exists not only in the United States, where differential treatment has been found to be associated with a patient's race, ethnicity, sexual orientation, sex, language, level of education, and age, but is to be found in other countries as well (Blair et al., 2013; Burgess, Fu, & Ryn, 2004; Khosla, Perry, Moss-Racusin, Burke, & Dovidio, 2018; Kitts, 2010; Street, Gordon, & Haidet, 2007; Trawalter, Hoffman, & Waytz, 2012)). As an example, Roma and Middle Eastern populations have experienced discrimination in a number of European countries, which has adversely affected health outcomes (European Union Agency for Fundamental Rights, 2013; Matrix Knowledge Group International Inc., 2014; Milcher, 2006; Silberman et al., 2016). Such sentiments are likely held by some health care providers in those countries and may account, at least in part, for the health care disparities seen.

1.1 Cultural competence and cultural sensitivity

U.S. education, including medical education, has often focused its efforts on the development of cultural competence, defined as a

process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each (Gallegos, Tindall, & Gallegos, 2008: 54).

Although it has been suggested that cultural competence is key to overcoming negative perceptions of minority individuals and groups (Ashley, 2014; Zhou, Siu, & Xin, 2009), the implementation of cultural competence programming may, in fact, reinforce generalizations about a particular group. The toolkits that are often developed in an effort to promote cultural competence utilize what are essentially averages or commonalities that exist within a particular culture in an effort to promote understanding of a particular group and a recognition among health care providers that their own beliefs and values may not be shared by their patients. However, because these generalized characteristics do not reflect

the diversity that exists within a particular group, a provider's understandings from such training may not be relevant and may not apply to a particular patient (Dressler, Oths, & Gravlee, 2005; Vandebroek, 2010).

Cultural sensitivity refers to „the extent to which ethnic/cultural characteristics, experiences, norms, values, behavioral patterns and beliefs of a target population as well as relevant historical, environmental, and social forces are incorporated in the design, delivery, and evaluation of targeted health promotion materials and programs” (Resnicow, Baranowski, Ahkuwaia, & Braithwaite, 1999). Although cultural sensitivity has frequently been lauded as a means by which to develop cultural competence (Kumpfer, Alvarado, Smith, & Bellamy, 2002; Resnicow et al., 1999), it has become increasingly clear that cultural sensitivity as an approach and cultural competence as a goal fail to adequately prepare faculty to address issues such as unconscious bias with their students or practicing health care providers to interact and communicate effectively and compassionately with their patients (Acosta & Ackerman-Berger, 2017; Kumagai & Lypson, 2009; Wear, 2003; Wear, Kumagai, Varley, & Zarconi, 2012).

1.2 Cultural Humility and Cultural Safety

More recently, medical educators have made efforts to broaden their curricular focus to include the concept of cultural humility. Whereas „competence” suggests the development and mastery of a specific set of skills or knowledge (Isaacson, 2014; Fisher-Borne, Cain, & Martin, 2015), cultural humility conceives of a lifelong process through which the provider engages in self-critique and intercultural learning (Tervalon & Murray-Garcia, 1998). Engagement in this process requires that the health care provider remain open and self-aware (Chang, Simon, & Dong, 2012; Foronda, Baptiste, Reinholdt, & Ousman, 2016). Unlike the concept of cultural competence, which conceives of the provider as the holder of relevant knowledge and expertise, the concept of cultural humility recognizes that much of what the provider needs to know resides with the patient rather than the provider (Chang et al., 2012; Foronda et al., 2016; Isaacson, 2014). Cultural humility replaces cultural competence's focus on the information to be acquired with an emphasis on the *process* by and source from which information is to be learned.

In effect, the embodiment and effectuation of cultural humility requires a redistribution of power within the provider-patient relationship in order to facilitate more open and informed communication and a more equitable interaction (Juarez et al., 2006; Tervalon & Murray-Garcia, 1998). This can only occur through the creation of a space characterized as one of

cultural safety, in which the provider engages with the patient from a value-neutral perspective such that the patient is neither blamed nor discounted (Ramsden, 1990, 1993, 2002; Ramsden & Spoonley, 1993).

2. Teaching Cultural Humility, Creating Cultural Safety: Sociodrama as a Method to Enhance Diversity and Inclusion Efforts

There remains the question of how to foster an approach of cultural humility within an academic medical center, among both students in the context of their learning experiences and faculty through professional development offerings. Sociodrama offers the possibility of transformational learning because it can encourage participants to reflect about the assumptions that underlie their “habitual ways of perceiving, thinking, feeling, and behaving” (Mezirow, 1981: 19).

Sociodrama is derived from psychodrama, a therapeutic technique for work with groups that was developed by Jacob L. Moreno in the 1930s (Blatner, 2000). Psychodrama has been explained as „a method for exploring psychological and social problems by having participants enact the relevant events in their lives instead of simply talking about them” (Blatner, 2000: 1). Psychodrama is to be distinguished from role playing that provides only opportunities to pretend an identity; in contrast, the psychodramatic enactment is intended to foster self-reflection on the part of the participants.

Sociodrama is a technique that facilitates examination of sociocultural interactions and situations, allowing both the individuals participating as actors in the drama and those in the audience to develop a deeper understanding of the dynamics and tensions involved in a given situation (Blatner, 2006; Kranz, Ramirez, & Lund, 2007). It has been described as „an experiential group-as-a-whole procedure for social exploration and intergroup conflict transformation” (Kellerman, 2007: 13). Although the technique derives from psychodrama, it is focused on a general inquiry rather than personal issues (Moreno, 1953, 1972) and therefore transcends the individual (Kellerman, 2007). As an example, a sociodrama might focus on the encounter between a health professional and a patient or student, in which one of the parties is the target of a derogatory comment focusing on their race, ethnicity, or sex, that is, a microaggression. In addition to exploring the motivations and emotions that may be experienced by each person in such a situation, the sociodrama facilitates a discussion relating to larger issues and themes inherent in the scenario, such as racism or sexism (Sternberg & Garcia, 1989).

Two different schools of sociodrama have developed. One focuses only with the group as the whole (Kellerman, 2007), whereas the second views each actor as “the bearer of collective roles and a representative of the common themes of the entire group” (Kellerman, 2007: 18). Either of these approaches can be utilized to:

- clarify conflicts in intergroup conflicts
- foster critical questioning
- build an awareness of how individuals may feel alienated and dislocated and
- help to develop empathy and
- provide an opportunity for individuals to explore possible responses to a variety of situations.

2.1 Sociodrama: The Method

The set-up of a sociodrama requires an empty space for those participating in the sociodrama and space for the observing audience to view what will unfold. Ideally, the space in which the actual participants are situated will be slightly raised so that those in the audience will have a clear view. The usual size of the group will consist of at least 20 persons, but can range from this number to include approximately 100. Even with a smaller number of observers and participants, it is advisable that the facilitator work with others as a team so that someone is available to provide individual support to observers or the scene’s participants, if needed, and to assist in keeping track of what is happening. In general, a sociodrama will require 1 to 2 hours.

Blatner has delineated four phases in the use of sociodrama to explore a particular situation: (1) warm-up, (2) selection and exploration of a theme through the use of sociodrama, (3) close-out and sharing, and (4) general discussion.

The warm-up phase is intended to create a sense of safety and trust among the participants and develop group cohesion (Blatner, 2006). It is important to develop a sense of playfulness among the participants during this initial phase, in order to reduce individuals’ level of anxiety and foster a sense of openness. This can be accomplished through the use of physical activities that enable participants to interact with each other. The development of a sense of trust and openness among the participants is critical due to the sensitive nature of the issues to be explored.

Either the facilitator leading the sociodrama or the participants may select the theme or the focus of the sociodrama. Themes can be drawn from a variety of sources, including historical situations, dilemmas found in

literature, and health-related concerns (Black, 1978; Blatner, 2006). As one example, a sociodrama might examine the underlying motivations of the investigators who conducted the Tuskegee syphilis study and/or the thoughts and feelings of the men who participated in that study. Scenarios for a sociodrama can be drawn from current situations that often confront medical students, staff, and/or faculty, e.g., sexual harassment, the use of pejorative language, a patient's seeming unwillingness to adhere to a recommended regiment of care, discriminatory behavior (Grieco & Chambliss, 2001). This author suggests that the facilitator select and structure the scenario that is to be the focus of the sociodrama in order to be certain that the sociodrama addresses issues of diversity and inclusion and has the potential to foster cultural humility.

The second phase of sociodrama involves the exploration of the chosen theme. During this phase, the actors in the scene utilize psychodramatic techniques in order to elucidate the issues that underlie a specific interaction or conflict. Several different approaches are possible.

One sociodramatic approach involves the assignment of a role to individuals to act out one of the roles in the scenario. The "director"/facilitator may pause the action to ask the actor(s) to modify their verbal or nonverbal behavior, which allows additional nuance in the roles. Alternatively, the director may stop the action and ask that someone else step into the role. Because this new actor may play the role differently, this approach also has the potential to help both the actors and the observers develop new insights.

One of the most powerful sociodramatic techniques that can be used during this second phase is that of the double. Each actor has a double, another actor who stands/sits behind him or her in the scene. This double verbalizes aloud thoughts that the actor to whom they correspond might be thinking, but is not themselves verbalizing. Each actor in the scene also has a double, who does the same thing. The doubles do not hear each other and do not respond to each other, but they convey to the audience what may be the innermost thoughts of the actor to which they correspond.

Let us assume as an example that a resident has had an unpleasant interaction with a patient. The patient has refused to be treated by the resident because the resident is African American and the patient wants to be seen only by a White physician. In this example, one actor would play the role of the resident and another the role of the patient and each would have a double. The progression of the sociodrama might look something like the following:

- Resident-actor speaks, introducing self to patient

- Resident-double speaks, revealing what the resident might actually be thinking as he/she speaks to patient. This is heard by everyone in the scene, but is not acknowledged by anyone. The resident-actor may integrate the substance of what the double said in a later response.

- Patient-actor speaks in response to resident-actor.

- Patient-double speaks, revealing what the patient might actually be thinking as he/she speaks to resident. This is heard by everyone in the scene, but is not acknowledged by anyone. The patient-actor may integrate the substance of what his/her double said in a later response.

The actors and their doubles speak in first person (“I”), thereby assuming responsibility for their words and actions (Kranz et al., 2007). The scene continues, permitting a deeper examination of the thoughts, feelings, and experiences that may be associated with the actual situation. Depending upon the complexities inherent in a given situation, each actor may have multiple doubles to allow exploration of conflicting loyalties and perspectives.

It is important to remember that the double may or may not be verbalizing thoughts and feelings that they themselves possess, but are reflecting the deeper issues that may exist in such situations. The thoughts and feelings expressed by the doubles are often never verbalized by people in “real life”; sometimes, an individual may not even know that he or she has such thoughts and feelings and it is as much of a surprise to them as it might be to the audience. If the facilitator has been successful in creating a safe space, the actors will be able to speak freely, without feeling the need to be constrained by what might be deemed civil or correct (Kranz et al., 2007) and the members of the audience will understand and accept that the views expressed by the actors and the words that they use may not reflect who they are. It is critically important that people refrain from judging others and allow themselves to be authentic in the process. Sociodrama can, accordingly, be helpful to individuals in developing an understanding of their own behavior and how they may be perceived by others (Williams, 1975).

The third phase is critical to allow the actors, the doubles, and the audience to debrief, particularly if the sociodrama has addressed an emotionally charged issue. During this phase, the actors in the sociodrama share the thoughts and feelings that they experienced in their roles. Individuals who observed the sociodrama also share any observations, ideas, and feelings that they may have had while watching the sociodrama. The following questions may be helpful as prompts for this discussion:

- What has been learned? Did you learn anything new about yourself or about how others may feel or respond?

- Are there any new insights into how anyone is feeling, the impact of the event, statements, etc.?
- What, if anything, surprised you?
- Did you identify with either of the actors or their doubles? If so, why?

Often, the sociodrama exercise will have evoked strong feelings. During this third phase debriefing, the facilitator will want to ensure that the discussion remains focused on individuals' responses and reactions to what happened in the sociodrama and that it does not stray into a deeply personal discussion of individuals' past personal experiences or psychological issues. Although individuals' pasts may play a part in how they view what happened during the sociodrama, an exploration of their personal issues in the group context would likely derail the ability of the group to debrief and could inadvertently lead to a (re)traumatization of the disclosing individual (Moreno & Moreno, 1969).

The fourth phase permits a more general discussion of the larger theme of the sociodrama. As an example, the fourth phase of a sociodrama involving the above scenario might involve a general discussion of microaggressions and strategies to respond or intervene in such situations.

2.2 Examples of Scenarios for Sociodrama

This author has utilized actual events in academic medical centers as the basis for sociodrama enactments. Some elements may be modified in order to enhance their effectiveness with a particular audience. For example, an incident that involves two faculty members may be modified to include a faculty member and a student or a faculty member and administrator.

The scenarios provided below are drawn from actual incidents and serve as examples of ones that this author has used. While it is recognized that readers may find these offensive, the intent in providing them is to illustrate the kinds of situations that may arise and, because they do arise in real life, they can serve as the basis for sociodrama and the development of greater understanding, empathy, and cultural humility. (It is also recognized that, depending on the institution and jurisdiction in which these incidents arise, they have the potential to lead to administrative and/or legal consequences.)

Scenario 1: A senior faculty member encounters a more junior faculty member in the hall. The senior member looks up and down at the junior faculty member and says, somewhat scornfully, "Aren't you a little too ethnic?"

Scenario 2: Several faculty members and students are standing in a hallway discussing their focus of research. Suddenly, a male faculty member turns to the others and, pointing to a female student, says, “Doesn’t she have great boobs?”

Scenario 3: A faculty member learns that another faculty member is Muslim. At a department party, he publicly refers to his colleague as a terrorist and demands to know why he is in the country.

Scenario 4: Several students in a cohort of medical school students are members of a group that is underrepresented in medicine, e.g., African Americans in the United States, Roma in Eastern Europe. Several other students who are members of the majority population begin a conversation on Facebook claiming that the minority students were admitted to medical school only because of their minority status and that their presence is indicative of declining quality of the medical profession.

2.3. Essentials for Using Sociodrama to Foster Cultural Humility

The following points are essential to the successful use of sociodrama to foster cultural humility.

- Develop clear learning objectives for the session and ensure that these learning objectives are tied to the scenarios that are to be used for the sociodrama exercise.

- Ensure that the scenarios to be utilized are relevant to the audience.

- Allow adequate time for the warm-up and the development of a level of trust and cohesion within the group.

- Establish ground rules with the actors and the audience.

- ⇒ The scenes and the dialogue may be triggers. Assume good intentions on the part of the actors and audience members.

- ⇒ The goal is openness and the development of new insights.

- ⇒ Refrain from judging others.

- ⇒ Be honest.

- Provide clear directions to the audience and actively involve its members.

- Allow sufficient time for debriefing.

- Avoid sifting into an individual or group therapeutic encounter.

- Provide a list of resources that address the issues that arise in the context of the scenario so that individuals can follow up if they so choose.

Conclusion

The development of cultural humility and safety is critical to efforts to reduce unconscious bias and discrimination that affect not only provider-patient interactions, but have implications for healthcare outcomes and health inequities. Sociodrama provides one means by which health care professionals can better understand their own unconscious biases and explore how to effectively respond to the biases of others. It also serves as a mechanism that can be used by educators in the health professions to foster the development of cultural humility and safety in their students.

Acknowledgment

Portions of this manuscript were presented by the author as part of a presentation by Hobson-Rohrer, W., Hoffman-Longtin, K., Liu, H.Y., Loue, S., Love, L.M., Pollart, S.M., Power, C.M. Active learning on center stage: Theater as a tool for medical education. AAMC Annual Meeting, November 11-15, 2016, Seattle, Washington.

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