

EMBODIED LEARNING AS A TOOL FOR MEANING-MAKING: A FORUM
THEATRE TRAINING

by

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DEDICATION

I would like to dedicate this to my sisters Nkeiru Suaray and Chioma Akagha. Thank you for believing in me.

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ABSTRACT

Embodied learning, while beginning to gain attention in Adult education literature, is still the least discussed method of learning (Lawrence, 2012). There is still no clear cut understanding or concretizing of how the mind body and emotion contribute, and interact with in the adult learning process. The study aims to identify how the mind, body and emotions contribute to meaning-making, and seeks to make concrete the concept of embodied learning in the field of adult education, specifically, medical professional development. The study looked at the use of Forum Theatre to train physicians to work effectively in the unfamiliar settings they likely will encounter in global health. As an arts-based qualitative research, the study applies ethnodrama and dramaturgical analysis in its methodology. The results reveal that mind, body and emotion are intertwined in meaning-making, culture and social anxiety influence meaning-making, and embodied learning facilitates seeing something familiar as new or different in meaning-making. The study results identify a need to incorporate more embodied learning strategies into the field of Adult education.

I. INTRODUCTION

How to improve workplace training has always been an area of interest for me from my days spent working in Zenith Bank Nigeria until this very moment in the United States. I remember how trainings were organized for the operations staff in Zenith Bank on Saturdays. I always felt like I could be doing more productive things with my Saturday, rather than spend all day at a training. The day would start at 9am and end at 5pm with my Saturday almost over. The training consisted of unending pages of do's and don'ts on the job and negative consequences of going against these set rules. Instances of customer service officers who had gone against these set rules were always used to instill fear in those of us who were at the training.

After these trainings, I would return to work on Monday and discover that what was said at the training was not what obtained at the office. Each case was peculiar to each branch. The style of doing things in branch A was different from the way things were done in branch B and both were different from the way things were done at the head office. Expectations were met based on the culture of the branch/head office you worked at. As a new employee, this approach tended to throw me off and required some time to adjust to the reality of what is on ground in practice as against what was taught in the training. To a certain extent it almost felt as though I was doing the wrong thing because it was slightly contrary to what was obtained in training. Maybe if I had been availed of the realities of what the current customer service officers actually practiced I would have been a little bit more prepared for these differences and I probably would have thought faster on my feet as a newbie. The originality of those contributions would have also prepared me to think outside the box when faced with peculiar situations. For instance, as

a customer service officer responsible for account opening, training stipulated that all documentation must be complete before any account can be opened. However, upon getting to the job, I was shocked when the head of my department and the branch manager opened an account with incomplete documentation. They signed a waiver form regarding the incomplete documentations required. The idea was that these waivers provided the account officers with a time period of two to three weeks to regularize the much-needed documentation in order to meet with the requirements and stipulations as set by the Central Bank of Nigeria (CBN). However, most of these accounts were never regularized and business carried on as usual until the routine audit check came round. During this audit period, account officers and customer service officers would begin running helter-skelter to provide the pending documentations. There was no training provided for this scenario except that we were told to ensure that we were never in such a situation or else we could lose our jobs if something fraudulent ever occurred with that account.

Later, as a graduate teaching assistant in my masters' program, I realized that the training provided talked about the challenges we were having, only after we received the evaluations by our students. Thus, this was most times carried out one-on-one with our graduate teaching assistant coordinator. We would meet during the semester every week to go over rules and regulations, and address how we were coping with teaching while staying in good academic standing. If there were challenges experienced by colleagues, we would mainly discuss them with one another depending on how familiar we were with one another. We would discuss the syllabus for teaching our classes but most of the challenges discussed came from the perspective of the coordinator. In this situation, the

personality of the teaching assistant determined the extent to which set expectations were met. A major limitation of this training was that most of the challenges or problems addressed came mainly from the coordinators perspective and not as much from the experience of the graduate assistants. Maybe it would have been more helpful if we shared our experiences from the field more explicitly with one another in the class. That way we would have learned what we could have done in such situations. This would have better prepared us for challenges we might have encountered as graduate teaching assistants. After these experiences, I find that my interest regarding workplace training is piqued as regards how effectively the training could be carried out so that both facilitator and learner look forward to the experience and come away from the training, learning even more than they had expected. If my experiences are typical of others' experiences in workplace training, then it is little wonder that according to Baldwin and Ford (1988), American industries spend over \$100 billion on training and not more than 10 percent of the expenditures result in transfer to the job. Less than 30 percent of what people learn in training actually gets used on the job (Robinson & Robinson, 1996). Mitchell (1978), states that most job training programs are designed for upper level employees and they emphasize attitudes and interpersonal behavior, however the major drawback is the lack of transferable experiences. The 2013 state of the industry report of ATD (Association of Talent Development) reveals that U.S. organizations spent \$164.2 billion on employee learning and development. More money is being spent on these activities because of both the increased rate of change in technology and people (Mitchell, 1978).

In thinking about how we can improve training, I reflected on my own learning experiences and discovered that I had multiple occasions where I engaged in learning

through embodiment. Growing up in a family where my siblings and I listened to stories told by my father at night under the moonlight, singing and dancing in tune with the songs he would teach us in these stories, one could say that meaning-making for me was largely accessed through the rigors of physical expression. Obtaining a B.A in dramatic arts heightened my love for the expression of oneself using the body. I believe my childhood and adult learning experiences had a huge impact on my learning style, my appreciation for the body in the learning process, and my biased preference for such a learning approach. One particular adult learning experience was in my PhD program. The class was models of inquiry: understanding epistemologies. The course objectives were for students to construct and deconstruct methodologies; identify multiple ways of knowing; question aspects of education and society; and begin to articulate personal epistemologies and value systems, and how they might inform the research process. We had an assignment called an interview-based/ documentary style drama presentation and discussion. In groups of four or five we were to perform a drama scene from an assigned philosophical/ paradigmatic perspective. In carrying out this assignment, my group wrote a fully scripted scene with speaking lines, and body movements. In developing the script we all delved into our own lived experiences and shared them with one another, to make meaning as it related to the philosophical/paradigmatic perspective we would enact before the class. In performing this scene, we embodied varied perspectives associated with constructivist/constructionism.

Our focus was on the sociocultural effects of technology in education. This learning experience for me was revelatory and exciting. It allowed me to break down a philosophical concept in such a way that I could relate with and identify the contributions

of this paradigmatic philosophy to inform my research process. This assignment was revelatory to me because it reconnected me to the way my father used stories to educate me as a child, and helped me identify my preferred learning style. In performing this scene, I made meaning of this philosophy using my mind, body and emotions. I portrayed a high school teenage girl, who was given an electronic tablet to help with her assignments. In using drama/performance to learn about this paradigmatic philosophy, theatre served as pedagogy for embodied learning.

In comparing my learning experiences as a child in my family and as an adult, with my learning experiences in the corporate world and as a graduate teaching assistant, it re-affirmed— to me— a need for developing creative and more interactive means of training the 21st century employee. This quest led to my interest in how the body and emotions of the employee can contribute to the individual learning and development of the employee, and development of the organization as a whole. Acknowledging the body in organizational and managerial activities, paves the way for a non-reductionist view on organizations, resulting in ample opportunities for new theory and better practices (Styhre, 2015).

The de-coupling of action from content or its expression is consistent with the dichotomous view of mind and body that pervades traditional schooling, higher education and workplace training. It is at the basis of the textual or anti-body orientation of schooling that has come down to us from the Enlightenment (Davidson, 2004). Observers in several professional fields have noted that traditional teaching practices are inadequate to preparing practitioners to meet the challenges they face in practice.

For example, in the field of medical education, Kumagai, White, Ross, Purkiss, O'Neal, and Steiger (2007) believe that preparing medical students to provide care to a diverse society requires more than the acquisition of a knowledge base in the biomedical sciences and the development of clinical and critical thinking skills. The practice of medicine always has human interests front and center and this way of being cannot be taught didactically through lectures, and assessed through multiple-choice exams, but must be acquired tacitly through reflection, dialogue and experience (Kumagai, 2014). Supporting that belief, Wasylo and Stickley (2003) conclude from a study on using drama in mental health nurse education that traditional teaching environments may inhibit students' potential to learn the fundamental skills of mental health nursing. In a study on embodied learning and patient education, Swartz (2012) found that embodied learning enhanced patients' adaptability to changing contexts through physical action, emotion, and interpersonal relationship, resulting in truly empowered patients capable of self-care.

Similarly, calls for changes in the ways teachers are trained are appearing in the field of education. Focusing on the persistent gap between theory and practice, Latta and Buck (2008) suggest that a pedagogy of embodiment should be central within teacher education. The authors believe that our pre-occupation with the disconnected has robbed us of bodily, participatory engagement. They suggest that it is time for teacher education to 'fall into trust'— which is the integral nature of embodiment— with the body's role in teaching and learning, acting on embodiment as a *Grand Idée* (p.324). The term 'falling into trust' is generated from the assumption that embodiment is elemental to human beings; and the body as the medium for sense-making entails falling into trust (Gottlieb,

2004). As a *Grand Idée*, the nature of embodiment has profound implications, particularly for education and the ways we think about how children learn, how teachers can teach, and how schools could be organized (Bresler, 2004). The need for more focus on embodied ways of training and embodied praxis are needed for teachers, if reconstructive practices and emancipatory learning by teachers and students alike are to be realized beyond rhetoric (lisahunter, 2011). These statements and research from both fields of medicine and education suggest that less dualistic modes of teaching are essential in learning, for professional training and development.

The assumption underlying most psychological approaches to education is that knowledge is somehow independent of the mind, and the body functions like a sensory object, but the problem with such approaches is that they are disconnected from the integral role embodiment plays in how we perceive ourselves, other persons and other things in the world (Stolz, 2015). Most of the studies on workplace learning focus on experiential and transformational learning, with little attention being paid to the processes by which students come to understand or make sense of something in a meaningful way (Carr, 2003). Since our engagement with the world is not just limited to the cognitive domain, we need to recognize that a large part of our interest in the world is emotional, practical, aesthetic, imaginative, and so on (Stolz, 2015).

Embodied learning, according to Merriam, Caffarella and Baumgartner (2007) is learning in an experience as it occurs rather than from reflecting on the experience after it occurs. Stolz (2015) defines embodied learning from an educational point of view as coming to know ourselves and the world around us better, neither as an abstract object nor as an instrument, but as a 'lived body'- subject that senses and does the sensing in a

meaningful way. To Merleau Ponty (1945) the body is not an object but a subject of action. The experience of things in the world is lived from an embodied point of view. This perspective emphasizes the need to understand how the role of the body as a lived experience influences meaning-making.

However, our understanding of the role of the body in the adult learning process is still in its infancy. Much of what has been written has been more conceptual than research-based (Tobin & Tisdell, 2015). What is known about embodied learning in the field of adult education is that the body has wisdom to teach us and can help learners fulfill their human potential (Lawrence, 2012). Today in the field of adult education there is still no clear cut understanding or concretizing of how the mind, body and emotion contribute to and interact within the adult learning process.

Definition of Terms

The major concepts for this study are mind and learning, embodiment and learning, and emotion and learning. For the purposes of this study, I adopt the following definitions:

Mind: The element of a person that enables them to be aware of the world and their experiences, to think, and to feel; the faculty of consciousness and thought (Oxford dictionary, n.d).

Emotion: A natural instinctive state of mind deriving from one's circumstances, mood, or relationships with others (Oxford dictionary, n.d).

Body: The ground of all sense-making (Latta & Buck, 2008) and the general medium of our existence (Bowman, 2004).

Embodiment: An embodied form of reason deeper than a superficial rationality and one that has the power to govern our passions and regulate ourselves (Peters, 2004).

Meaning-making: A dynamic process involving the self, reflection and experience which can be developmental and transformative (Merriam & Heuer, 1996).

Purpose of the Study and Research Questions

The purpose of this study is to make concrete the concept of embodied learning in the field of adult education, specifically, medical professional development. This study aims to identify how the mind, body and emotions contribute to meaning-making in the adult learner in a training situation, specifically the professional development of medical students.

I will address the following research questions:

- a. How does the mind contribute to meaning-making?
- b. How does the body contribute to meaning-making?
- c. How does emotion contribute to meaning-making?

In looking at how the mind, body and emotions contribute to meaning-making, I hope to develop a more detailed understanding of how embodiment contributes to adult learning.

Theoretical Perspective and Epistemological Influences

The theoretical perspective for this study is embodied learning. As stipulated by Merriam, Caffarella and Baumgartner (2007), the non-Western theme of a holistic approach to learning lays emphasis on the spirit, mind, body and emotional components of learning or some combination of these over the Western focus on the cognitive.

My epistemological perspective for this study is primarily informed by my African Igbo culture, and my African indigenous perspective. Mans (2004), identifies the relationship between my African indigenous perspective and embodied learning by stating that,

In the Cartesian dualism of mind versus, and controlling, body has never been an African understanding. Here in Africa mind and body are traditionally conceived as one and the same. One knows life through one's body. Life is embodied-felt and experienced ("erlebt") in all its sensory levels and learning is situated in physical experience, not dissociated intellectual pursuits. Hence, the body and its ability to move in meaningful ways is more than just a vision of physicality (p. 80).

This relates to Merleau Ponty's (1945) perspective on the theory of the body schema as implicitly a theory of perception. By remaking contact with the body and with the world, we shall also rediscover ourselves, since, perceiving as we do with our body, the body is a natural self and, as it were, the subject of perception (Merleau Ponty, 1945). My African indigenous perspective and the Merleau Pontian approach both embrace the idea of the merging of the body and senses as a site for learning. They also look at learning as going beyond the surface of the "vision of physicality" to more meaningful ways that can contribute to giving us different perspectives through which we can "rediscover ourselves".

Nigerian Igbo woman. My cultural influence in this study is that of a Nigerian Igbo woman. My Igbo culture is an oral culture. Oral transmission as a mode of preserving culture has survived through the ages by young men and women learning the intricacies of the tradition under the guidance of older (veteran) artists. Oral artistry,

according to Boadu (1990), serves three broad purposes: ritual, entertainment, and education. The oral traditions narrated with care and repetition, additionally constituted the African child's training in what was often a complicated linguistic system without a script (Datta, 1984). I remember when I once tried to give something to my mother and I used my left hand. She scolded me, telling me to never do that next time. Giving something to your elder with your left hand was a sign of disrespect. The left hand is seen as the hand that is used to carry out all the nasty tasks such as picking up of a dirty object, washing or wiping the backside after defecating. There was no written script that stipulated these do's and don'ts but after that experience with my mother, it was registered in my mind as taboo to give people things with my left hand.

The pedagogic role of the artist in the traditional African society is illustrated by the art of storytelling. An elderly person tells stories to the young ones around the courtyard in the moonlight; the storyteller performs not for financial gains, but for artistic commitment, teaching the children the moral values of the society and exposing the sociocultural background of their society (Boadu, 1990; Datta, 1984). Story-telling, proverbs and initiations are strong forces in socializing children. They teach endurance, healthy competition, valour, initiative, industry, respect for elders, justice, oratory, palaver mode of discussion and so on (Ezeuchenne, 2010).

"Tales by moonlight" was one of my favorite TV shows growing up. This show not only served to entertain me but taught me morals and socially accepted norms of behavior. The show began with little children seated under a tree in a village square awaiting the arrival of the storyteller to share stories with them. The story teller would begin the tale, and actors would enact the story for viewers at home. For instance, she

may begin by asking if anyone knows why the tortoise shell looks cracked. It is based on this question and the responses from the children seated around her that she begins her story which in turn becomes an actual enactment of the tale. At the end of the enactment, viewers at home are returned to the scene with storyteller and the children. The storyteller asks the children what morals they learned from the story. The responses from the children also made viewers at home like me become more conscious of what had been learned.

An interesting aspect of this experience is that no one ever knew the name of the story teller, she is always referred to as “Aunty” which is a way of addressing a female who is much older than you and whose name you do not know. If you were related to the lady in question and knew her name, you could mention her name but only after mentioning the word ‘Aunty’ initially before her name. Using myself as an example I would be referred to as Aunty Chinedu. At the end of each segment, the kids always hurried home to meet their parents seeing as it was dark by the time the stories were done being told. This supports what Boateng (1990), suggests about oral literature serving as an important educational vehicle for the youth in traditional Africa through fables, folktales, legends, myths and proverbs. Not only did the stories teach morals, but the exchange between the children and the story teller exemplified the socially accepted standards of communicating with those much older than you.

The learning process is greatly influenced by tradition (Boateng, 1990). Thus, my African culture, coupled with my B.A in Dramatic arts, contributed to my social - construction perspective for this study and my interest in arts as a creative practice in workplace training. African education unlike the formal systems introduced by the

colonialists was inseparable from other segments of life. It was there not only to be acquired but also to be lived (Boateng, 1990). The theatre reflects the life and the ethics of the community (Traoré, 1972). The African audience's perception of theatre is far from escapism or mere entertainment; it conceives of theatre as a place for sharing ideas and communing with human beings, gods and spirits (Ukala, 2001). The theatre in the African setting takes its place in a framework of institutions whose aim is to make members of a society accept common values, thereby contributing to the control and integration of feelings and beliefs (Traoré, 1972).

In a study on the Igbo masquerade drama, Nwabueze (2000), identifies three major motifs of the masquerade drama as the praise motif, the satiric motif and the expressive motif. While the praise motif contains attitudes of behavior which the community considers worthy of emulation, the satiric motif contains attitudes of behavior which the society wants avoided. The expressive motif is designed to make philosophical statements that express the norms and values of the society. It is usually in the form of proverbs usually structured in the form of contradictory appellation. This process reveals that the drama in the Igbo Nigerian setting plays a role in educating the members of the community on the accepted standards of living and behaving within the society. Ezeuchenne (2010), views the masquerade as an essential part of the community that embodies a deep seated social value and expresses the will of the community. These examples from my cultural practice as an Igbo woman, and my theatre education buttress my epistemological assumption of social constructionism and how it influences my study.

African indigenous perspective. The following quote below speaks to this concept of the African indigenous perspective,

African scholars and scholars of Africa need to take advantage of academic and intellectual spaces opened by postmodern, postcolonial, and cultural studies theorists to rationalize African intellectual developments as explicitly African reflections upon the specific experiences of African historical agents. This is vital because African historical agents have made and continue to make their own histories; these histories do not portray Africans as only “primitive” conquered subjects, resistors, and/ or collaborators (Creary, 2012, p.10-11)

As a Nigerian Igbo woman with an African upbringing and culture, I identify with this statement by Creary. I draw on my African cultural experience to give an added perspective to the lived experiences of the African individual. These reflections will in turn provide a certain history in which others like me can identify with and also contribute to the knowledge base of other forms of life experiences that may exist for the African individual.

According to Higgs (2007), the experience of an African reality gives rise to a sense of a commonality in an enunciation of an indigenous African epistemology which finds expression in certain general themes in African philosophy, one of these being the discourse of community in Africa which is also referred to as communalism. Community and belonging to a community of people constitutes the very fabric of traditional African life. This leads to the role of social constructionism in my epistemological perspective.

Social constructionism proposes that meanings are constructed by human beings as they engage with the world they are interpreting (Crotty, 2007). All reality, as meaningful reality is socially constructed. We import meanings to the objects from our culture. These culturally inherited meanings arise out of interaction between humans and the realities in their world (Crotty, 2007). Social constructionism influences this study in that it provides an avenue through which I can better understand the factors influencing the meaning- making process.

Intellectuals- African and Africanist alike- have significant roles to play in decolonizing the knowledge of Africa that the academy, the media and the arts portray (Creary, 2012). I am hoping that by linking my African experiences to embodied learning through the use of theatre, both worlds (Western and Non-Western) can come to appreciate their strengths in the field of education and combine these perspectives to achieve a more richly balanced learning of both worlds in the educational process. As Higgs (2007) suggests, community-based research in higher education should be to help integrate indigenous and community-based knowledge systems into higher education curricula, while at the same time expose indigenous communities to knowledge production and dissemination founded on indigenous cultural and social values.

Theatre as a Pedagogy of Embodied Learning

Artistic expression can be a powerful way to access embodied knowledge, and as adult educators, we need to understand the many ways adults learn and design learning strategies to meet the needs of an increasingly diverse group of learners (Lawrence, 2012). My personal experience in performance arts reinforces for me, theatre as a pedagogy of embodied learning. Drama reveals textual understanding, provides

opportunities for deeper analysis and critical thinking about texts and concepts (Macro, 2012). A collection of studies on performance, illuminate performance as a process of sense making that takes head on—the charge of understanding the nature of human cultural experience, of sense making and the processes of acquiring knowledge through embodied experience (Alexander & Myers, 2010). Mentors support and challenge students, and in adult education support is most easily effected by working with and from the learner’s experience base (Merriam & Heuer, 1996). A pedagogy that incorporates drama, gives students a framework to understand the world around them and a rich experience from which to learn (Macro, 2015). Based on the perspective that experience and nascent knowledge are bound to people’s bodies, Pässiliä and Oikarinen (2014) argue that knowledge creation through art-based processes has a tacit and embodied dimension.

Embodied perspectives hold that our engagement with the world is neither purely theoretical nor entirely cognitive; it is also emotional, practical, and aesthetic (Stolz, 2015). Thus, we come to know a thing not only by theorizing or thinking about it but also by feeling, doing and appreciating it (Forgasz, 2015). Through theatre performance, the learner comes to know through embodiment. Performance as enacted, embodied engagement, takes on the metaphorical experience to process both meaning and understanding, and to rehearse possibilities of transformation, intervention, and change (Alexander & Myers, 2010). In order to be effective guides, as adult educators, we must first understand the process of meaning-making, learning and development. Making sense of, interpreting and making meaning of our experiences is what learning in adulthood is all about (Merriam & Heuer, 1996).

In linking meaning- making and learning, Jarvis (1992) states that learning is about the continuing process of making sense of everyday experience – and experience happens at the intersection of a conscious human life with time, space, society, and relationship. Learning is therefore a process of giving meaning to, or seeking to understand life. Theatre as a pedagogy of embodied learning provides adult educators and learners alike with a platform for meaning-making of their lived experiences. It creates a richer meaning-making process by including other aspects such as feelings, emotions and actions.

Site for the Study and Participants

The site for this study was in a university in South Central Texas. The training was focused on preparing medical students for global health work. Forum theatre was applied in this training in order for medical students to become more adept at thinking about the broader contexts that impact patient health. It was also applied in order for students to have a better understanding of structural determinants of health, their impacts on and barriers to maintaining and promoting good health, and to help them explore potential interventions to mitigate these structural barriers to health. Forum theatre is a play or scene, usually indicating some kind of oppression. The play or scene is usually shown twice. During the replay, any member of the audience (‘spect-actor’) is allowed to shout “Stop!” and to step forward and take the place of one of the oppressed characters, showing how they could change the situation to enable a different outcome.

Forum theatre, as the platform for my study, lends itself to arts–based research (ABR) on performance inquiry. Arts–based research explores the artistic process and brings forth new differentiations on the levels of intuition, perception, emotion, embodied

and craft-based knowledge and intellect (Prior, 2013) thereby providing me with a multitude of perspectives to better understand the contributions of embodiment to meaning-making. Arts-based research took me beyond the surface actions to understand the below the surface catalysts to meaning-making.

The participants were fourth year medical students who were preparing for global health work and their upcoming internship positions. I chose this site because theatre enables learners bring mind, body and emotion to learning. This site was beneficial to my study because of the use of Forum theatre as a tool for training. The location of the site was also an added advantage to my study for data collection because of its proximity. This was the third year that this form of training was used in the global health training.

Methodology

This is a qualitative arts-based research (ABR) study with an ethnographic frame. Arts informed research is a way of redefining research form and representation and creating new understandings of process, spirit, purpose, subjectivities, emotion, responsiveness and the ethical dimensions of inquiry (Cole & Knowles, 2008). I employed ethnodrama, a representation of data in qualitative research by the qualitative researcher who playwrites with data (Saldaña, 2003), to represent my ethnographic data. The basic content for ethnodrama is the reduction of field notes, interview transcripts, journal entries, and so forth to salient foreground issues— the “juicy stuff” for “dramatic impact” (Saldaña 1998 pp.184-185). Langer (1951) suggests that interdisciplinarity among the arts would expand human intellect and bring about more complex, more imaginative ways of understanding human experience. Scholars in ethnography have much to contribute to those initially educated as artists, and artists well versed in the

creative process and products of theatre have much to offer ethnographers (Saldaña, 2003). The methodological integrity of the research is determined in large part by the relationship between the form and substance of the research text and the inquiry process reflected in the text (Cole & Knowles, 2008). Therefore, a performance inquiry with an ethnographic frame resulted in ethnodrama as an appropriate mode of representation for this qualitative study.

I chose this methodology for my study because it allowed me delve deeper into understanding the meaning-making that occurred during the learning process. I chose ethnodrama because it lends itself to performance based research. Ethnodrama allowed me present rich, textured, descriptive, situated, contextual experiences and multiple meanings from the perspectives studied in the field (Leavy, 2013). With embodied learning as the bedrock for my study, ethnodrama created ample avenues through which I identified how the mind, body and emotion, contributed to meaning-making.

Data Collection and Analysis

I collected data through interviews and participant observation. The interviews helped my study by providing me with the participants' perspectives on their experience of Forum theatre as a tool for training. I audio recorded these interview conversations and transcribed them for data analysis. Data was also collected using video recordings of the Forum theatre production with the participants. The videos were important to my study because they enabled to examine the physical body activities of these participants in order to understand how the mind, body and emotions contributed to meaning-making. The data were coded using in vivo coding as recommended by Saldaña for use with ethnodrama (2016). In vivo coding adopts the terms used by participants themselves to

code the data. From that coding, I identified themes to answer my research questions. In vivo coding contributed to evoking the originality and helped me to truly represent the voices of the participants in my study. Dramaturgical analysis, which is established on the premise that peoples' day to day lives can be understood as resembling performers in action on a theatre stage (Goffman, 1959), was also applied to the data. Due to the nature of this study as an art-based performance inquiry, dramaturgical analysis provided deeper insight to participants' motives, conflicts, and attitudes in this study.

Importance of the Study

The study contributes to the building and refining of theories of embodied adult learning by providing a description of how the mind, body and emotions contribute to meaning-making through an embodied learning process, Forum theatre. It contributes to the practice of professional development by documenting how theatre can be used to engage minds, bodies and emotions in learning.

The study contributes to expanding epistemologies used in qualitative research by drawing on the strength of both Western and my Non-western epistemology in conceptualizing and researching how a non-dualistic approach contributes to adult education and by identifying the benefits and contributions of embodied Non-western practices to adult education in Western practice. It generates a structure for embodied learning to be more easily identified and understood in relation to meaning-making in Western practice, using performance theatre.

Chapter Summary

The contribution of mind, body and emotion to meaning-making is the center of this dissertation research. It looked at the meaning- making process of fourth-year

medical students who were trained using Forum theatre. This study understands meaning-making as a dynamic process involving the self, reflection and experience which can be developmental and transformative (Merriam & Heuer, 1996). In applying a hermeneutic approach to this art-based performance inquiry, this study adopted an ethnographic frame in its methodology, adopting ethnodrama (Saldaña, 2003) and dramaturgical analysis into the meaning-making process of the fourth-year medical students involved in the study.

II. LITERATURE REVIEW

To carry out this review of the literature, I searched for keywords like embodied learning, embodied learning theory, cognitive learning, Cartesian mind-body dualism, Descartes Cartesian dualism, Forum theatre, Forum theatre origin, embodied learning and the workplace, organizational learning, embodied workplace training, embodied pedagogy, creative pre-service teacher training. I highlighted the peer reviewed column in Ebscohost during my search. The search engine generated academic journals, books, dissertations/theses, conference materials, and review publications from 1863 – 2016. Using the same process, my search on the Cartesian dualism generated publications ranging from 1899 - 2015. The academic journals and books selected provided a foundational background for the scope of this literature review. The search results provided the current research in my area of interest and allowed me trace the gradual progression from one phase to the next.

Cartesian Dualism

In the sixth meditation of his philosophical essays, Descartes (1964) writes that he is a thinking being, whose essence consists solely in being a body which thinks. Through Descartes' influence, the West has tended to remove memory and un-mathematicized imagination from the process of learning thereby restraining the human imagination (Redpath, 1997).

According to Descartes (1964),

I am a thinking being, I readily conclude that my essence consists solely in being a body which thinks [or a substance whose whole essence or nature is only to think] ...I am only a thinking and not an extended being; and on

the other hand I have a distinct idea of body, in so far as this is simply an extended, non- thinking thing. And accordingly, it is certain that I am really distinct from my body and can exist without it (p. 132)

Thus, mind and body are therefore, two kinds of substance[s], each of which is distinctly different, and can exist independent of each other (Akomolafe, 2012).

Therefore, since one can form a clear and distinct idea of mind as a thinking thing and a clear and distinct idea of body as an extended thing, they are essentially distinct, (Flage, 2014). Thus, the Cartesian mind-body dualism views the body as distinct from the mind, and the individual as a thinking being.

The Cartesian mind-body dualism has led to Western style education which seldom gives overt attention to the body (Akomolafe, 2012; Osgood- Campbell, 2015; Kerka, 2002; Styhre, 2004). As a result, Western style educational systems still privilege cognitive reality (Wagner & Shajahan, 2015). Feldman (1970) states that cognitive theory with its emphasis on concept development, represents the survival in education of Plato's theory of knowledge which is contempt for sense knowledge and perceptual activity and a somewhat mystical belief in the existence of unchanging essences or ideas. By the time we reach adulthood, "being in our bodies" is a foreign concept and a source of discomfort for many of us (Lawrence, 2012 p. 1). How then does this cognitive emphasis influence workplace learning?

Workplace Learning

Marsick (1987) defines workplace learning as,

A way in which individuals or groups acquire, interpret, reorganise, change or assimilate a related cluster of information, skills and feelings. It

is also primary to the way in which people construct meaning in their personal and shared organizational lives (p.4).

In other words, workplace learning can provide a platform for individuals to acquire new skills that contribute to the meaning- making process of the personal and shared organizational lives.

Training is defined by Mitchell (1978) as learning. Clark, Nguyen and Sweller (2006), emphasize that more information and more complex tasks demand greater skills, which require more training in an efficient training environment proven to work in harmony with the strengths and limitations of human learning process. Scarinzi (2015) states that education can become the ritualistic repetition of what we have done or been told without our possession of knowledge that is in any way our own, consequently it is necessary to combine intellectual effort with performing effort if something worthy of the name learning is to result. That is to say that combining a performing effort in the learning experience helps the learner turn the knowledge obtained into something they can call theirs'. Training is effective if it is learner centered, performance based, reinforced on the job and suitable for overcoming the gap between current and desired results (Stolovitch & Keeps, 2002).

According to Antal (2014), numerous techniques to stimulate and sustain organizational learning already exist, but the size and scope of problems require experimentation with fresh approaches like artistic interventions which can lead to creativity and different possible ways of seeing and dealing with the world. Antal (2013) suggests that the foreignness of artists is attractive to managers seeking fresh ideas, perspectives and practices for their organization, and the foreignness of the organizational

setting offers the artists new possibilities. McNiff (2014), observes that when working with people in the area of creative expression, a common fear of appearing foolish or strange arise and, feelings even approach terror when people are offered the opportunity to express themselves in new ways with their bodily, vocal, poetic, or visual expressions. This leads us to the concept of creative instructional practices present in the 21st century workplace.

Arts-based Learning in the Workplace

Jarvis and Gouthro (2015) conclude that arts-based education facilitates the capacity to accept and identify differing interpretations of reality which is central to successful professional practice given the increase in diversity in workplaces. For instance, Somerville and Lloyd (2006) found that manual handling training for assistants-in- nursing (AINs) was radically transformed when applied to the workplace. This was because the relationship of one body to the other can only be learned in practice due to constantly changing body shapes and sizes of both workers and patients. Differing body shapes result in differing interpretations of reality. In the use of role-play in medical communication training, Jacobsen, Baerheim, Lepp and Schei (2006) found that “the fourth wall” created through role-play, presents an additional tool for new understanding of fiction based communication training. The role play created a platform for differing interpretations of reality from the doctor communicating with the shy withdrawn patient, breaking bad news and communicating with the aggressive patient. Delving into these differing interpretations of reality provide the medical practitioner with more possible meanings which might have been initially overlooked.

Jarvis and Gouthro (2015) in their review found that some educators use arts to help professionals develop a critical understanding of their work, unmask oppressive practices and understand and express their own concerns about injustice. For instance, Sutherland (2013) is concerned about how we address students' diverse identity locations in an equitable manner, so as to narrow the gap between existing policies and our authorized talk about race, and how race is lived, experienced and embodied across our universities. To achieve this aim, Sutherland (2013) examined the role of theatrical performance as a means of addressing the embodied and spatio-temporal manifestations of race and racism within South African higher education. The author found that there is a need to put the body back into knowledge making. In this example, the author speaks to post-conflict higher education practitioners in South Africa on addressing race issues, but this approach may be easily adopted by educators all across the globe to address such difficult conversations.

Rappaport (2013) emphasizes a need to educate others to understand that what comes through the arts and what is symbolized through the arts is essential because words alone cannot capture the felt meaning. Hence, it is one thing to read or hear the words, but it feels different to embody these words through action. Wagner and Shahjahan (2015) remind us that, despite these benefits of embodied learning, introducing embodied learning activities in the contemporary neoliberal context of higher education is fraught with challenges and risks depending on the social position of the instructor.

Theatre of the Oppressed

Theatre of the oppressed is often referred to as a body of theatrical techniques (Cohen-Cruz & Schutzman, 2006). *Theatre of the oppressed* (1985) is an homage to

Paulo Freire who in *Pedagogy of the oppressed* (1968) foregrounds the process of conscientization whereby poor and exploited people learn to conduct their own analysis of their social, political, and economic reality (Cohen-Cruz & Schutzman, 2006; Freire, 2014). Education for Freire (2014) must begin with the solution of the teacher-student contradiction, by reconciling the poles of the contradiction so that both are simultaneously teachers and students (p. 72).

Director, theorist and political activist, Augusto Boal, was appointed director of Brazil's Arena theatre in 1956. He experimented with egalitarian forms of theatre he believed would foster democracy in an increasingly socially and repressive Brazil by working with groups of Brazilian citizens in performances. He encouraged the citizens to enter into the action on stage as a way to rehearse for social change. As a result of his oppositional work, in 1971 Boal was arrested, jailed and tortured (Bell & Jones, 2008). He moved in exile first to Argentina and then to Europe. During this time Boal refined his ideas and techniques, which culminated in the publication of *Theatre of the oppressed* in 1974. He revealed that he was much inspired by Freire's idea that a teacher is someone who learns (Schechner, Chatterjee, & Boal, 1998) and translated this idea into a theatrical context (Cohen-Cruz & Schutzman, 2006).

As Freire broke the hierarchical divide between teacher and student, Boal did same between performer and audience member (Cohen-Cruz & Schutzman, 2006). Boal's poetics of the oppressed focuses on the action itself where the spectator becomes the performer, changes the action, tries out solutions, discusses plans for change, and trains oneself for real action (Bell & Jones, 2008).

The four major techniques developed by Augusto Boal which move the theatrical stage to the streets and draw on various degrees of audience participation include: Simultaneous Dramaturgy, Image theatre, Invisible theatre and Forum theatre (Bell & Jones, 2008; Cohen-Cruz & Schutzman, 2006; Jackson, 1992). The initial three techniques will be briefly explained while I will go more indepth with Forum theatre as it is my major platform through which I hope to understand the workings of embodied learning in workplace training.

Simultaneous dramaturgy. This is a technique designed to involve spectators in a scene without requiring their physical presence onstage (Cohen-Cruz & Schutzman, 2006). Performers ask spectators to propose a short scene on some topic of importance to the group. The scene is developed by the performers and raising the action to the moment of climax, the performers ask the audience to offer solutions to the problem presented. This type of performance begins to demolish the wall that separates actors from spectators. An example of this is found in the playback theatre. Here, audience members are invited to the stage to tell a story and then watch that story as it is enacted on the spot by performers. The teller, having witnessed his/her story played back then has an opportunity to comment and have the final say about the story (Bell & Jones, 2008).

Image theatre. In image theatre, the spectators become part of the performance (Bell & Jones, 2008). Image theatre is a physical form of aesthetic communication not reliant on verbal mastery where participants silently sculpt each other into tableaux that express ideas and experiences that are then dynamized to further explore their ramifications (Cohen-Cruz & Schutzman, 2006; Jackson, 1992). The goal of image

theatre is to arrive at an image which represents a consensus among the participants (Boal, 1992).

An example of image theatre is the scene of unemployment which Boal carried out in Europe (Boal, 1992). In France and Denmark, the scenes of unemployment were very similar with a never-ending queue leading up to a young woman typing. Near her there were other people working, while everyone on the queue had long faces. The only major difference was that in Denmark, the people on the queue were smiling and distributing political pamphlets. It seems that the people were smiling in Denmark because the social security system was more generous and the unemployed could get up to 90 percent of their salary. Due to this fact, they took advantage of the situation to engage in a variety of activities including politics, by distributing the pamphlets (Jackson, 1992).

Invisible theatre. Invisible theatre is public theatre involving the public as participants without their knowing it (Cohen-Cruz & Schutzman, 2006; Jackson, 1992). It has a text with a scripted core and, modified according to the circumstances to suit the interventions of the spect-actors. In invisible theatre, participants take the play to a place which is not a theatre and perform it for an audience which is not an audience (Boal, 1992).

An example is the show *what would you do?* The show is hosted by John Quinones on ABC primetime television. Here the actors perform a well-rehearsed and scripted play amongst the unknowing public audience. The subject themes are usually focused on current social issues such as, bullying, homelessness, blind faith, human rights, just to mention a few.

Forum theatre. In Forum theatre, audience members become conscious players in the action. Forum theatre begins with the performance of a short play, or anti-model that embodies a social problem featuring a protagonist working hard to solve a problem but who nevertheless does not succeed (Cohen-Cruz & Schutzman, 2006; Jackson, 1992). Forum theatre is pedagogical in the sense that everyone learns together, actors and audience. The play must represent a mistake, a failure, so that the spect-actors will be spurred into finding solutions and inventing new ways of confronting oppression (Jackson, 1992). Spectators who identify with the oppression in the play are invited to replace the protagonist and act out their own possible solutions to the particulars the play presents, thus rehearsing action for revolution in everyday life (Bell & Jones, 2008; Cohen-Cruz & Schutzman, 2006; Jackson, 1992).

In Forum theatre, the joker is the person who acts as intermediary between audience and performers and is attached to no one party. The joker is both a narrator who addresses the audience directly and a wild card able to jump in and out of any role in the play at any time. The joker has a polyvalent role as director, master of ceremonies, interviewer, and exegete, representing the author who knows story, plot development and outcome as no individual character can (Schutzman, 2006).

Spect-actor is a Boal coinage (1992) used to describe a member of the audience who takes part in the action in any way; as opposed to the passivity normally associated with the role of audience member. All human beings are actors (they act) and spectators (they observe) they are spect-actors. The effect of the Forum is all the more powerful if it is made entirely clear to the audience that if they don't change the world, no one will change it for them (Boal, 1992).

‘Magic’ as in ‘Stop – that’s magic’ refers to interventions in Forum theatre which move from reality to the realms of magic or fantasy. For instance, a spect-actor who takes the place of a penniless protagonist and suddenly finds a thousand pounds on the road; this is probably magic in that it is unrealistic (Boal, 1992). Magic is a term which refers to the solution of a problem by unlikely and unrealistic means (Telesco & Solomon, 2001). However, as in all cases, it is up to the audience to decide if that is magic or reality.

In another instance, when a scene is performed again in Forum Theatre exactly as in the first enactment, the spect-actors can replace any performer by shouting “Stop!” The new spect-actor takes over that performer’s role, leading the action in a better or more productive direction (Bell & Jones, 2008). The part of the evening where the spect-actors start to intervene in the action on the second showing is referred to as ‘forum.’ Boal believed that the aim of Forum was not to give solutions or incite people, but rather to let them express their own solutions (Taussig, Schechner, & Boal, 1990). In Forum, roles are not fixed, not only character but the roles of “actor,” “playwright,” and “director” are also not fixed, thereby buttressing the transitive pedagogy of Forum (Taussig, Schechner, & Boal, 1990).

In an interview with (Schechner, Chatterjee, & Boal, 1998), Boal stated that in each country, people have to adapt theatre of the oppressed to their own culture, language, desires and needs for Forum Theatre is not a Bible, or a recipe book, but rather a method to be used by people. For instance, Quinn (2014) explores the work of the independent Forum Theatre troupe in Senegal called Kaddu Yaraax. This troupe addresses questions of Senegalese theatrical heritage and positions itself vis-à-vis notions

of pre-colonial, colonial and contemporary performance. This study gives an example of how Forum theatre is adapted to the situation of things in Senegal which is the country in which it is being practiced.

At the base of both *Pedagogy of the oppressed* and *Theatre of the oppressed* is the truth one cannot teach if one does not learn from those one is teaching (Schechner, Chatterjee, & Boal, 1998). In a study by Hewson (2007), on an arts-based action research project examining her actions as facilitator/ joker and exploring Forum theatre's potential for redressing oppressions in a school setting, emotion was identified as an important factor to consider when deciding how best to respond in the moment, whether as joker or as classroom teacher. With truth as a base in theatre of the oppressed, Hewson (2007) acknowledged her own fear of the situation presented as she played the role of the joker. This acknowledgement allowed her question in retrospect why she went with the suggestion of force, to control the given situation, rather than the common sense position initially suggested. Her reason was due to the fact that the suggestion of force was more familiar, even though it was not what she wanted (p. 12). How then does one channel the embodiment of these emotions to arrive at the best possible result in workplace learning?

Forum Theatre in Practice

Through the process of metaxis, theatre becomes the space for interplay between the actual and the imagined, the tangible and the ephemeral. The notion of embodiment is central to understanding this in-between state because meaning emerges through our bodies acting in a metaxic space (Linds, 2006).

Boal (1995) defines metaxis as,

A state of belonging completely and simultaneously to two different, autonomous worlds: the image of reality and the reality of image. The participant shares and belongs to these two autonomous worlds; their reality and the image of their reality, which she herself has created, (p. 70)

For instance, in a study by Levy and Stagg, (2007) one of the scenes implemented was called shimmer. The scene shimmer was used to address the issue of routine which resulted in frustration that arose from boredom at work. Two characters were portrayed. One of the characters used her lunch break to escape in a positive way and recharge her batteries. Work to her was repetitive but she looked towards the external natural environment as a kind of relief. The second character had found that the work itself was joyful and satisfying and had connected with the rhythms of mechanical in work that surprised the first character. Forum theatre aimed at exploring this issue and helping employees explore their own relationship to work and their perception of others. The piece generated heartfelt debate and led to much follow-up reflection on differences between people at work and how routine is managed.

The removed nature of this piece allows participants reflect more fundamentally on their own specific relationship to routine and diversity. This scene in the study provided a “space for interplay between the actual and the imagined, the tangible and the ephemeral” thereby allowing participants see the image of their reality and the reality of their image in order to obtain a better understanding of the two worlds they belong to, while trying to find the balance between both worlds.

In the field of education, Forum theatre has been used to explore issues of emotions (Hewson, 2007); community-based environmental science (Sullivan & Lloyd, 2006); homelessness (Hamel, 2013); theatre in education (Ball, 1995; Telesco & Solomon, 2001); training and development (Rae, 2013); organizational change management (Descubes & McNamara, 2015); organizational intervention (Levy & Stagg, 2007) citizenship (Howe, 2009). Although present in educational research, Forum theatre is not without its challenges.

Criticisms of Forum Theatre

Rae (2013) identifies the expectations and pressures that Forum Theatre facilitators are subject to, stipulating that they are contradictory and conflicting. They are supposed to be in a democratic space and yet are expected to contribute to outcomes that are predetermined. For instance, in the study by Hamel (2013), the Forum theatre practitioner shied away from a more critical approach when faced with potential funders in the audience to whom he directly spoke during the event. Herein lays the crucial tension because, artists thrive on the openness of a project. Managers seeking new solutions understand the need for arts in the project, but funding bodies and policy makers increasingly demand clear deliverables against which to measure the impact of their investment (Antal, 2012), thus leading to pre-defined versus emergent outcomes. Pre-defined in this situation refers to the view of management or funding body as against emergent outcomes being organically generated as a result of genuine interaction amongst spect-actors.

The power of the facilitator to direct the way in which issues are addressed can be more manipulative than liberating, contrary to expectations (Rae, 2013; Telesco &

Solomon, 2001). Nicholson (2005), states that in the organizational context, the intentions of Forum theatre are purely instrumental and Machiavellian. However, the study by Rae (2013) revealed that the participants of the Forum theatre workshop showed a general belief that the event did stimulate discussion and lower defensive behavior. Thus, there is still the hope of giving voice to the voiceless.

Since Forum theatre was created in the context of third world resistance in which physical oppression and repression were daily realities, it is far removed from the Western and European education system where oppressions are more subtle (Ball, 1995). This difference helps to reiterate what Boal in an interview stated that in each country, people have to adapt theatre of the oppressed to their own culture, language, desires and needs, because forum theatre is not a Bible, or a recipe book, but rather a method to be used by people (Schechner, Chatterjee, & Boal, 1998). In one study, Saldaña (1999) using Forum theatre to determine adolescent perceptions of oppression, the author discovered that for this group, equity was not a matter of race or class but rather freedom from stigma and inclusion in peer group membership. Social justice for them referred to their immediate social circle of peers and the fulfillment of personal desires. Oppression surfaces when the individual adolescent whose needs or characteristics varies from adult expectations or group cultural norms becomes targeted for terrorism: exclusion, intimidation, ridicule, coercion, manipulation, negation of desires, and at its worst, physical violence.

Ball (1995), also states that most Forum theatre exercises rely on practical conflict situations which do not always provide opportunities for examining the processes of distancing and reflection. Forum theatre is likely to be most effective if it can be used as a

method for providing stimulus for participants to access and view their own experiences and form emotional connections to those experiences (Elm & Taylor, 2010; Taylor & Ladkin, 2009). For instance, in the study by Hamel (2013) on homelessness, participants were asked to describe a best and worst living climate they had experienced in their lives. The climate described by one of the participants was so oppressive that it prompted him to resort to the streets. This significant moment of disclosure was set aside and not included in the performance, as it was deemed too personal to be explored, thereby dodging the opportunity to bring this particular participant to embody his own narrative of pain and rejection as a way to better understand his own feelings of disenfranchisement (Hamel, 2013).

Learning within organizations should provide individuals with space to consider their own position and contribution within the organizational context (Rae, 2013). If these embodied emotions and feelings are not examined during the learning process, how then can an employee contribute effectively to the growth of both company and self? According to Telesco and Solomon (2001), shared experiences of people in a theatrical space, makes it possible to deconstruct the self, look at the self within a problem situation from multiple view points and put it all back together into an ability to take action. This statement further buttresses the focus of this study on creative instructional techniques as an avenue for embodied learning in the workplace. Three major areas identified within the literature of embodiment include, embodied learning; embodied cognition and embodied pedagogy.

Embodied Learning

Embodied learning, from an educational point of view, involves coming to know ourselves and the world around us better, neither as an abstract object nor as an instrument, but as a 'lived body' - subject that senses and does the sensing in a meaningful way (Stolz, 2015). Horn and Wilburn (2005) state that embodied learning challenges traditional views of learning that focus on either, the gathering and cataloging of pre-defined facts, or the honing of prescribed methods of thinking. Embodiment, embodied learning and somatic learning are terms used interchangeably (Kerka, 2002), while some authors discuss embodied learning differently than somatic learning (Freiler, 2008). Somatic learning refers to learning directly through bodily awareness and sensation during purposive body-centered movements (Freiler, 2008).

Embodied learning, while beginning to gain attention in Adult education literature, is the least discussed method of learning (Lawrence, 2012). The most influential philosopher of embodiment in the twentieth century was and still is Maurice Merleau-Ponty, whose thoughts on the body's direct and immediate grasp of the world have inspired a lot of theoreticians as well as practitioners (Alerby, 2009; Holst, 2013). Tobin and Tisdell (2015) observe that there has been little consideration of Merleau-Ponty's philosophy of the body in considerations of embodied learning in adult education. The heart of his philosophy is the role of the body in the dialectic of the pre-reflective and the reflective; he argues that the body functions as a general instrument of comprehension (Merleau-Ponty, 1945; Tobin & Tisdell, 2015). By making contact with the world, we shall also rediscover ourselves, since perceiving as we do with our body, the body is a natural self and, as it were, the subject of perception (Merleau-Ponty,

1945). Thus, the human rationality is rooted in human perception, and self-knowledge is mediated through bodily expression and action in the world and through time (Glenn, 2015).

It is impossible to separate the unity of the mind and the body from its relationship with the world through perception or experience (Stolz, 2015). Both empiricism and intellectualism are eminently flawed positions for Merleau-Ponty (Reynolds, 2004). Between empiricist explanation and intellectualist reflection there is a fundamental kinship- which is their common ignorance of phenomena. Both construct the hallucinatory phenomenon instead of living it - and this could lead to a kind of mental blindness (Merleau-Ponty, 1945). The milieu of Merleau-Ponty's philosophy of situation can accommodate rationality (cognition), but it also consigns it to its proper place because while his philosophy affirms the primacy of perception...this does not require that the validity of rational process be sacrificed (Reynolds, 2004).

Vlieghe (2014), objects to the belief that the Merleau-Pontian line of thought prioritizes and emancipates the body. On the aspect of pre-reflexive intentionality which is the source of all meaning-constitution, Vlieghe (2014) argues that the body is simply a resource we do not realize we possess and an instrument for achieving educational objectives that in the end have nothing to do with corporeality (p. 27). The Merleau Pontian body-centered approach of viewing the body as possessing intentionality and being the source of all meaning- constitution is similar to the significance of corporeity to the intellectualist and dualist view. Thus Vlieghe (2014), views this body-centered approach as being contradictory because the body is regarded as (educationally)

important in so far as it is capable of performing those meaning- makings, which was for a long time seen as the privilege of the solemn life of the mind (cognition).

The Merleau-Pontian approach imposes a false dilemma where one is asked to either comply with the superseded opinions like mind-body dualism or accept the far more plausible idea that the body is itself a carrier of meaning and that it therefore is educationally important (Vlieghe, 2014). Regardless of these criticisms Vlieghe (2014) does not deny that the body-centered approach of the Merleau-Pontian school of thought may be more efficient than traditional approaches to math training or social-justice education.

Merleau-Ponty's ideas have proven to be quite influential in the field of educational theory (Vlieghe, 2014) by attempting to rethink in a much more body centered way the practice of science education (Osgood-Campbell, 2015; Viteritti, 2013); physical education (Evans, Davies & Rich, 2009; Holst, 2013; Maivorsdotter & Lundvall, 2009; Standal & Moe, 2011) the creative writing process (Alerby, 2009; Cooper, 2011; Tobin & Tisdell, 2015) higher education (Sutherland, 2013); pedagogy (Ansell, 2009; Dixon & Senior, 2011; Rappaport, 2013; Wagner & Shahjahan, 2015); activism (Ollis, 2008); workplace learning (Byrge & Tang, 2015; Gärtner, 2013; Kupers, 2008; Küpers, 2012; Moats, Chermack & Dooley, 2008; Nottingham & Akinleye, 2014; Simola, 2014; Somerville & Lloyd, 2006; Styhre, 2004; Wainwright, Marandet, & Rizvi, 2010); online learning (Dall'Alba & Barnacle, 2013); and health (Swartz, 2012; Zavestoki, Morello-Frosch, Brown, Mayer, McCormick & Altman, 2004).

Embodied Cognition

Embodied cognition draws on a number of distinct traditions in philosophy, psychology and cognitive science (Stolz, 2015). The emerging viewpoint of embodied cognition holds that cognitive processes are deeply rooted in the body's interactions with the world (Lindblom, 2015; Osgood-Campbell, 2015; Wilson, 2002). The embodied cognition framework attempts to provide a more continuous explanation of perception and action on the one hand and cognition on the other, by suggesting that cognition is constituted in sensorimotor experiences (Pouw, Gog & Paas, 2014). Embodied cognition is evident in education through educational theorists like John Dewey, Alice and David Kolb and Maria Montessori, who posit that bodily action is inextricably related to mental processes, and therefore essential for effective learning (Osgood-Campbell, 2015). Although Dewey (2012), Kolb (1984) and Montessori (2001), are known for experiential learning in education, Kerka (2002) specifies that embodied knowing is experiential knowledge that involves senses, perceptions, and mind-body action and reaction.

Embodied Pedagogy

Embodied pedagogy can be defined as including embodied teaching and embodied learning, but is conceptualized through pedagogy as relational between teaching and learning, and teacher and learner (Dixon & Senior, 2011). Embodied teaching/ learning demands being in the moment at the juncture between self and other, and the continuous process of reciprocal interaction and modification is embodiment's significance in teaching and learning (Latta & Buck, 2008). In embodied pedagogy, our bodies are acknowledged as valid knowledge producers and elevated [in regards to value and importance], having its own value for generating focus, stillness and more

importantly, anchoring us in the ‘now’ moment (Wagner & Shahjahan, 2015). One way to increase the level of knowledge is to involve the whole body in the teaching and learning process (Alerby, 2009; Merleau-Ponty, 1945).

Jordon (2001), views embodied pedagogy as recognizing the importance of the body for both students and teacher by acknowledging that the location of our bodies affects our interactions with one another. This statement brings to light the importance of the body in the learning process. Latta and Buck (2008) believe that teacher education must fall into trust with the body’s role in teaching and learning. Harbrecht (2013), on adapting Forum theatre for GTA training, identified the opportunity provided by Forum theatre to connect the bodies and cognitive developments of new skills related to teaching. This is evident in her statement that, as we use our physical bodies in a space, performing those actions, we lock them in as memory, both in mental and corporeal forms. Forum theatre promotes the embodiment of multiple strategies for challenging issues in teaching that instructors can and do often face, which when adapted with purpose and careful thought, will assist their professional development and self-reflection process (Harbrecht, 2013). An embodied pedagogy not only calls us to evaluate our own use of space and body language, it also encourages us to use our students’ bodies on our teaching and to appeal to senses other than the auditory (Jordon, 2001). Thereby widening the various avenues through which the facilitator and student can interact in the learning process, leading to endless possibilities. Schaedler (2010) specifies that what educators need to understand is that it is not about the performance at the end but the process of using drama, the techniques and exercises that can open up a world of possibilities in the classroom

In a study about learning to train preservice teachers using theatre of the oppressed, Placier, Burgoyne, Cockrell, Welch, and Neville (2015), found that theatre of the oppressed has potential for making tacit knowledge and implicit beliefs about teaching among preservice teachers visible. This concept of visibility is supported by the proposition of Coult (1980) regarding theatre in education that theatre arts, makes abstract ideas concrete and personal. Once visible, they are accessible for reflection, discussion and ideally, development and change (Placier et. al, 2015). The visibility provided generates an opportunity through which the mind, body and emotion contribute to the meaning- making of the fourth-year medical students that were involved in this study. Forum theatre gives these fourth-year medical students a chance to experientially explore how they might resolve problematic patient treatment situations, while the physicality of the scene work makes it possible to consciously access and use our tacit knowledge about how these instances normally work (Hewson, 2007).

Butterwick and Selman (2012) stipulate how to go about using embodied pedagogy with adults and in general. It requires a form of attention using all our senses, assessing the costs, risks and benefits as fully as we can; inventing in response to our community rather than impose a theatre process recipe; being willing to move forward with caution and not blindly but with hearts and eyes wide open; viewing these stories as gifts that must be handled with care in gentle yet strong containers; letting participants know what the process will be; exploring individual and group self-care capacity; asking what agreements we have to move forward; and making the work count because the aim of this work is about the telling, listening and engaging with the truth of stories to inform

action. An embodied pedagogy provides a platform that promotes a more holistic process in meaning- making in the lives and practice of those involved in the learning situation.

Criticisms of Embodied Learning.

Some criticisms of embodied learning in the workplace include the unwarranted conclusion of Cartesian accounts to attribute rationality to the mind, whereas the body is either only a source for stimuli or, even worse, the realm of emotions and irrationality (Gärtner, 2013). The limitations identified in the enacted lived embodiment include: providing an objectified analysis about the body (contrary to enacted embodiment claims); also, the problem of equating knowing with acting because not every doing implies knowledgeability (Gärtner, 2013). In Western European education, the highest status is reserved for the most abstract and immaterial learning, irrespective of its utility, while lowest status is accorded to concrete material learning, much of which we acquire in daily embodied emotions. However, the use of embodied learning has been under-recognized (Morris & Beckett, 2004; Ollis, 2008).

Tobin and Tisdell (2015) observe that most contributions to the New Directions for Adult and Continuing Education volume on Bodies of Knowledge: Embodied learning in Adult education, recently edited by Lawrence (2012), were more conceptual as opposed to reports of research studies per se, and some of the authors connected the body and learning with theatre and the arts (Butterwick & Selman, 2012; Nieves, 2012) or dance (Snowber, 2012). In a thematic review article by Jarvis and Gouthro (2015) of the literature of arts and professional education, the authors state that the use of arts in professional studies may be one way to engage learners in developing the creative critical

self-reflective capabilities they will need in the workplace. Fenwick (2008) states that the workplace,

...can be an organization, a Website, a kitchen table, even a car. Work varies widely across public, private, and not-for-profit sectors, and among activities of tradesworkers, managers, self-employed professionals, farmers and domestic workers. Indeed, work itself is a slippery category; it can be paid or unpaid, based in action or in reflection, material or virtual, in or out of the home, or more often in various overlapping spaces among these categories. Just as neither workplace nor work can be referred to as some generic, identifiable phenomenon, so does learning in work take multiple forms, faces and qualities (18-19)

Since, embodied learning focuses on coming to know ourselves better as a 'lived body'... (Stolz, 2015), art could be seen to provide alternative platforms for learning in multiple forms, faces and qualities (Fenwick, 2008). Styhre (2004) believes that acknowledging an embodied view of the organization is to depart from a Cartesian reductionism and its theorems and axioms...thereby making the lived body irreducible to the level of textual and linguistic meaning. By using the theory of the lived body, learning is constituted when the experiences of a lesson are incorporated in the body, and these experiences blend with earlier knowledge and understanding to become habits (Alerby, 2009). Habit, for Merleau-Ponty (1945), is knowledge in the hands, which is forthcoming only when bodily effort is made and cannot be formulated in detachment from that effort. Hence, Standal and Moe (2011) view embodied learning as tied to a form of knowledge that primarily expresses itself in acts.

Chapter Summary

This body of literature provides more insight to the world of embodied learning through the use of Forum theatre in the workplace. Although not without its challenges in practice, Forum theatre provides us with the platform through which adult educators can identify the specific aspects of how embodied learning contributes to the meaning-making of adult learners. The mind, body and emotion are made more visible and concrete in the learning process, such that as adult educators we can specify how embodied learning, embodied cognition, and embodied pedagogy contribute to meaning-making. As a result, this body of literature ties in the relationship of art to learning and adults in the workplace.

Hammer (2001), believes that the involvement of audiences in theatre in education is structured to challenge their prior understandings and stimulate new insights, new questions, and new knowledge. Therefore, my hope is that the adult learner in experiencing this form of training becomes more involved in the learning process such that these challenges to their prior understandings generate meaning-making beneficial to both learner and organization.

III. PLAN OF INQUIRY

To better understand how mind, body and emotion contribute to meaning-making, I examined an instance of arts-based training. Eisner (2008) states that if we wish to engage students' emotions and feelings, artistic expression is best suited to provide a remarkable springboard to our own selves. The arts by their very nature, value embodied knowledge to a greater degree than many of the traditional disciplines found in school (Davidson, 2004). The form of art in this study is a performative art called Forum theatre.

This study aimed to find out how the mind, body and emotions contribute to meaning-making in the adult learner. Hence, the research focus of my study is to understand, depict, and concretize how Forum theatre, as an embodied approach to training fourth year medical students, about to begin their internship, contributes to meaning-making in the adult learner. I focused on the contribution of the mind, the body and the emotions to adult learning. The sub-questions for this study were:

- a. How does the mind contribute to meaning-making?
- b. How does the body contribute to meaning-making?
- c. How does emotion contribute to meaning-making?

In order to concretize this phenomenon, the data corpus is presented first as ethnodrama. This is followed by a Findings chapter, in which I present a thematic analysis carried out in the tradition of cartesian dualism. There, I present themes identified during an analytic treatment of my data that was focused on addressing the research questions.

Ethnodrama

Turner (1982) coined the term ethnodrama with the belief that scripting ethnography draws attention to cultural subsystems in a dramatic way, and also serves as an effective device for revealing the hidden, perhaps unconscious levels of action. These unconscious levels of action are the focus of this study and their contributions to meaning-making. An ethnodrama is the data corpus—with all the boring parts taken out. The basic content for ethnodrama is the reduction of field notes, interview transcripts, journal entries, and so forth to salient foreground issues—the “juicy stuff” for “dramatic impact” (Saldaña 1998 pp.184-185) the results are participant’s and /or researcher’s combination of meaningful life vignettes, significant insights, and epiphanies. This process generates the material from which the structure and content— its plot and story line— are constructed.

According to Mieniczakowski (2015), data drawn from forum discussions may be added to the performance script, which is periodically revised and amended as the representations given during performances change meaning. Ethnodrama performances are constantly updated according to data drawn from audience interactions (Mieniczakowski, 2006). Ethnodrama was chosen for this study because of its appropriateness as a medium for telling my participants’ story credibly, vividly, and persuasively (Saldaña, 2003). Thus, in ethnodrama the qualitative researcher playwrites with data (Saldaña, 2003). As a result, for the purpose of this study, ethnodrama is referred to as a representation of data in qualitative research.

On the relationship between ethnography and ethnodrama, Denzin (1997) connects the overall and rapidly expanding move towards ethnographic performance as a

logical turn for a number of human disciplines in which culture is increasingly seen as performance and performance texts as being able to concretize experience. Ethno comes from the Greek *ethnos* meaning “a people or cultural group” and *graphein* meaning “to describe” (Glesne, 2016). Ethnography is a qualitative design in which the researcher describes and interprets the shared and learned patterns of values, behaviors, beliefs and language of a culture- sharing group (Harris, 2001). Ethnography is the written representation of a culture (or selected aspects of a culture) (Van Maanen, 2011). This perspective speaks to my study in concretizing the contributions of the mind, body and emotions to meaning- making. This idea is further buttressed by Leavy (2015), who explains that the move to ethnodrama by some researchers is due to the ability of dramatic performance to get at and present rich textures, descriptive, situated, contextual experiences and multiple meanings from the perspectives of those studied in the field (p. 182). Ethnodramas and ethnographic performances are about “the present moment” and seek to give the text back to the readers and informants in the recognition that we are all co-performers in each other’s lives (Mieniczakowski, 2015).

Ethnodrama differs from the traditional Western canon of dramatic literature by maintaining close allegiance to the lived experiences of real people while presenting their stories through an artistic medium (Saldaña, 2005). This is because in ethnodrama, it is not only the individual characters who have dramatic importance, but also the deep processes of social life (Turner, 1982). In this ethnodrama, the interviews with the participants reveal the influences of social life on their mind, body and emotions in relation to meaning- making. The explanations, meanings and insights generated by ethnodrama performances are consensually controlled and created by informant groups

(Mienczakowski, 2015). In this research study, the informant group was the fourth-year medical community undergoing global health training.

The six steps in ethnodrama include

- Content and structure
- Participants and characters
- Monologue and dialogue
- The ethnographer role
- Visual action
- Adaptations and expertise (Saldaña, 1999).

Research Design

However, before I embark on discussing these steps, I would like to give a broad overview of my research activities carried out in this study. This provides a roadmap for the process I employed for this study. I divided my activity process into three different stages which include the pre-performance, the performance and post-performance.

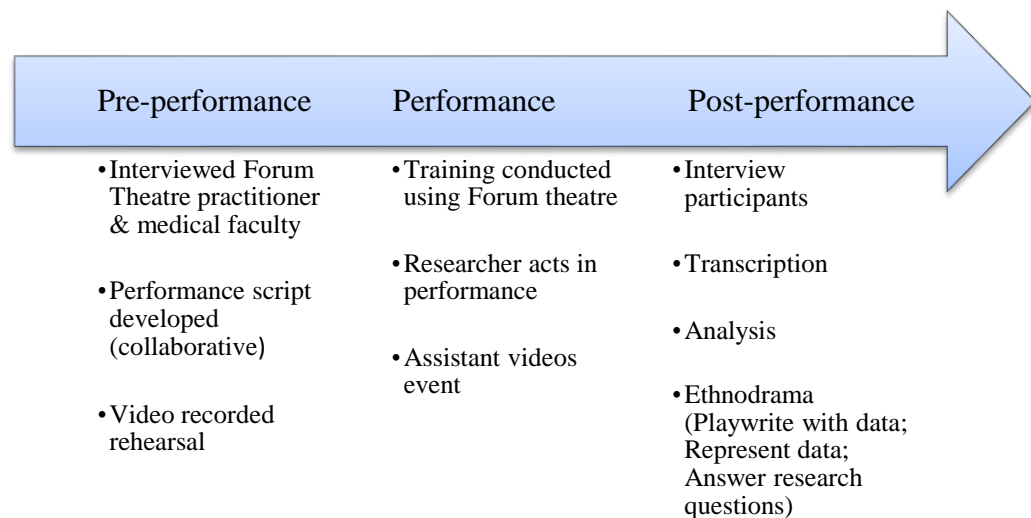


Figure 1: Roadmap

Analytic process. My analytic process in this study began even before I completed data collection. I remember speaking with excitement to my assistant on how interesting that our focus on this data as non-medical students was different from the focus of the medical students in the study. The data was deeply interwoven from participant interviews to the play itself. As a result, I read and re-read the transcripts of each participant separately and also in relation to the play. I made notes on the transcriptions and in my journal, of thoughts that struck me while reading them. I also watched and re-watched the video recordings of the performances in order to tally actions with words and expressed emotions. Re-reading the transcripts, I began to notice a trend in participants' responses.

The sheets on the wall. I lined the walls of my apartment with two rows of 20" X 23" self-stick tabletop easel pad/flipchart sheets, from the highest level my hands could reach on the walls, to the lowest convenient level on the wall that I could reach. There were eight sheets on one wall and four on another. Each sheet got gradually filled with clusters of words, page numbers from the transcripts, and phrases from the transcripts of the interviews and performance that spoke to a particular theme, as I read and re-read the transcripts and watched the video recordings. In writing these thoughts on the wall with different colored markers, I was able to immerse myself even deeper in the data and have it clearly mapped out before me to work on. The ability to lift the sheets and place them where they led created a feeling for me of the data being easier to handle, quite literally. Having the data on my apartment walls also made my access to the data extremely convenient because sometimes while watching a television show, a thought could strike me about my data and I could quickly write it into the theme it fell under.

Immersion and distancing. In immersing myself in this data I was able to classify, compare and label the emerging themes, while identifying certain areas in participant responses that needed further clarification. I would occasionally take a break from the data to have a fresh perspective on the data when I returned to it. Taking a break from the data to return later almost always guaranteed a new addition of scribbles of thoughts to the sheets on the wall. Discussing my data with my dissertation Chair generated a deeper sense of self-reflection which emphasized the importance of the hermeneutic philosophy to my process. This was because in interpreting myself and my participants as humans in this performance based inquiry, I arrived at a deeper understanding of myself and my participants. I found that the data generated themes which, developing a life of their own, dictated the order in which the data would be re-presented in the form of ethnodrama.

In adopting ethnodrama as the methodology for this study, I observed that most of the steps are similar to qualitative analysis research steps. Therefore, in discussing the six steps of ethnodrama above mentioned, I will identify the qualitative research step it is similar to. As a result, some of the ethnodrama steps will be listed as follows;

- Data collection — Content and structure
- Sampling — Participants and Characters
- Researcher role — Ethnographer role
- Verification — Adaptation

Data Collection —Content and Structure

In adopting the methodology of ethnodrama (Saldaña, 2003) for my study, I borrowed some general ethnographic techniques to explore and examine the cultures and societies of the workplace of my participants (Murchison, 2010, Wolcott, 2010). Through long-term immersion in the field, collecting data primarily by participant observation and interviewing, I developed the thick descriptions (Geertz, 1973) used for interpreting how people within a cultural group construct, share and negotiate meaning (Cresswell, 2006; Glesne, 2016). I observed and interviewed ten study participants which included fourth year medical students about to begin their internship as they underwent training that employed the use of Forum theatre in their preparation for global health work. It also included the trainer, the Forum theatre practitioner and one of the actors in the performance. Through this process, I was able to construct the data collected into ethnodrama.

Due to the peculiarity of the study as a performance art study involving the actions of people within the session, I started data collection before the actual training took place. This was possible through rehearsal and communication with the gate keeper, the Forum theatre practitioner and the medical doctor organizing the training. I collected data using video recording at rehearsal and on the actual day of performance, audio recordings of interviews, field notes, and journaling. I fortunately had some assistance with the video recording during the performance to effectively capture participants' verbal and non-verbal reactions to the actions on stage and their social interactions (Banks, 2007) thereby preventing Bottorff's (1994) concern of the missed opportunity to be an active participant. These non-verbal cues reveal much about characters— and real

people (Saldaña, 2003). The content for ethnodrama is the reduction of field notes, interview transcripts, journal entries, and/or memoranda to what are salient. In structure, the playwright fashions a plot- an overall structure- and from that develops a storyline. Turner (1982), describes this phase as where the know-how of the theatre people — their sense of dialogue; understanding of setting and props; ear for a telling, revelatory phrase — could combine with the anthropologists understanding of cultural meanings, indigenous rhetoric, and material culture.

The examining stage, to Wolcott (2008), requires the archival strategies of sifting through what has been produced or left by others in times past. Hence, I collected data from the training facilitator on the frequency of this form of training. The data gave me a deeper understanding on the history of their experience with this style of training in their establishment. It also provided a foundational base for me to better understand the progress in evolution of the ongoing training. Written documents like the play synopsis, character definition, and training session schedules, were also made available to me by the training facilitator. I made notes during rehearsal, the performance, and the environment in which they took place. These included the seating arrangement, the ambience, the level of interaction amongst the students before the performance, and how the use of technical jargon in this setting reinforced the culture of the participants. These data informed the scene settings in the ethnodrama.

Due to the collaborative nature of Forum theatre, the actors had the opportunity at rehearsal to contribute their personal experiences and ideas on what best suited the characters in each scene. Thus, as a collaborative effort, I contributed to the script development towards the actual performance. My cultural lenses contributed to the

interpretation of the character I portrayed in the play. As a female African from a developing country, I found that I borrowed from my cultural lenses to inform the character interpretation of the role I played in the performance. The character was a 26-year old female, who was HIV positive. I wrote in my journal, reflections on my experience of the rehearsal—meeting the medical faculty and theatre professionals involved in putting together the production, the rehearsal experience, acting in the production, and my thoughts on the interviews. These notes contributed to the data corpus in the ethnodrama as they were reduced to the “juicy stuff” for “dramatic impact” (Saldaña, 1998).

The interviews were semi-structured interviews carried out before and after the Forum theatre presentation. The participants served as one of the sources for interviewing (Seidman, 2006) and observation in the data collection for the study. The aim of interviewing trainees and trainers was in order to get a balanced view of the process of meaning-making in the adult learner. Those who did not come up on stage to act were asked questions that revealed the influence of the actions carried out by their colleagues on stage to their own meaning-making process. Those who did come up to act were asked why they did what they did in those particular instances. The facilitators were interviewed before and after the Forum theatre session to determine if their expectations for the training session were met. The trainees were interviewed after the Forum theatre session to further shed light on the process of meaning-making that occurred in the training.

Monologue and Dialogue

A monologue in theatre is an extended passage of text spoken by one character. The monologue reveals social insight with carefully selected detail and showcases a character through a snapshot portrait of his or her life taken from a particular angle. Dialogue is the playwright's way of showing character interaction and interplay, which are terms found regularly in qualitative research (Saldaña, 2003). Dialogue occurs when two or more character's exchange thoughts or confront an interpersonal conflict. Dialogue in this study was obtained from interview transcripts, performance and rehearsal transcripts, field notes, and journaling. The dialogue advances the action and reveals character reaction (Saldaña, 1999). The ethnodrama contained both dialogues and monologues.

The addition of a prologue and epilogue provides a contextual framing and reflection, respectively, about the story (Saldaña, 1999). In this ethnodrama there is a prologue and epilogue serving this purpose. They provided the context of the training taking place which was fourth year medical students preparing for their internship. It identified the facilitators and described the training process as Forum theatre. They also served as a check to determine if the training met their expectations. The dialogues and monologues in the data were obtained from the transcripts of the interviews, field notes, observations, and reflections.

Sampling— Participants and Characters

The site for this study was a university in South Central Texas. The training was entitled, "Preparing for Global Health Work". Forum theatre was applied in this training in order for medical students to become more adept at thinking about the broader contexts

that impact patient health. The learning objectives for this session were identified in the course syllabus as follows. By the end of this session students will be able to

- a. Understand the definition of structural determinants of health and how they impact people living in resource limited settings
- b. Identify specific structural determinants that are barriers to the health of the person described in the case through interactive Forum theatre/workshop methodologies and
- c. Explore potential interventions that could mitigate these structural barriers to health, and the impact (both positive and negative) of those interventions. For instance, in the payment for transportation to clinic, the impact is positive in terms of adherence to treatment visits, at times neutral in terms of success on antiretroviral therapy, and negative in terms of program costs.

The World Health Organization (2017) defines social determinants of health (SDH) as the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.

Access to the site for the study was obtained through contacting a Forum theatre practitioner who works alongside medical faculty in training medical students preparing for global health work. This practitioner has a number of academic publications that led me to him. Serving as a gatekeeper to this site, he linked me to the medical faculty responsible for organizing the global health training session. The Forum theatre session

lasted for an hour and 26 minutes. This is the third year that Forum theatre has been used to train fourth year medical students towards global health work. The cast of characters in the ethnodrama were participants' whose stories emerged as noteworthy (Saldaña, 1999). In this study, the stories of ten participants were regarded as noteworthy to compose the cast of characters in the ethnodrama.

Researcher Role — Ethnographer Role

I was asked to act as a character in the play because they were short of hands. I obliged, further contributing to my role as a participant observer (DeWalt & DeWalt, 2002). This active participation (Spradley, 1970) helped combat my initial concern of coming out of my reserved personality to become comfortable enough to approach possible participants. As stated by DeWalt and DeWalt (2002), the personal characteristics of the researcher may influence the level of participation that an individual may choose to adopt. By participating in the Forum theatre process both in the script development and the acting, I applied myself as the research instrument to experience, enquire and examine (Wolcott, 2008) the occurrence.

Participating in the behind-the scenes production of the play, I gained insight to the workings of the medical community that I would not have otherwise been privy to (DeWalt & DeWalt, 2002), thus further informing my understanding of the deep processes of their social life (Turner, 1982). For instance, I was able to meet with the medical instructor, develop a rapport and discover that the script was based on actual events from her global health experience. I was also privy to hearing the challenges that they experience as medical practitioners in the field of global health. It was eye opening to observe that even though they went to different parts of the globe, they almost all had

similar challenges concerning ethics, patient care, and identifying allies while maintaining international relations. Taking part in the production, I believe contributed to the willingness of the trainees to participate in the study when I approached them. This speaks to the perspective of Richards and Morse (2012) who suggest that in the ongoing process of interpretation and data collection, the researcher must reflect on what is being found and how, including the role of the researcher in finding it.

In ethnodrama, my role as the researcher is to examine if my presence as a researcher on stage with the participants is vital to the story and outcome. This means that in writing my data into ethnodrama, if I discover that my presence as a character in the ethnodrama will be beneficial to the flow and meaning of the ethnodrama, then I will write myself in. However, if I find that the ethnodrama can be written without any reference to me and still convey the data to the reader, I can then write without infusing myself as the researcher. In this ethnodrama I did not write myself in as a researcher because I found the latter to be the case. The researcher having a role in the ethnodrama may or may not help to facilitate the explanation of the data collected to the reader (Saldaña, 1999). Thus, I decided against being written into the ethnodrama as a researcher.

Data Analysis

As an arts-based performance study, the data required me to go over the video recordings and transcribed data simultaneously, and audio recordings and their transcriptions. The analysis of the data reduced the 149- page transcription, and 171- minutes video corpus for core content examination to (Seidman, 2006) a 50-page ethnodrama. A combination of in vivo and dramaturgical coding was applied to the

analysis of the data (Saldaña, 2009). I linked multiple pieces of participant data for triangulation (Miles & Huberman, 1994), and in vivo coding for category development (Saldaña, 2009; Strauss, 1987). Participant voices from two or more data sources can be interwoven to offer triangulation (Saldaña, 2003). To achieve this, I read and re-read the transcription and field notes repeatedly for familiarity, alongside the video and audio recordings to funnel the data, selecting and re-interpreting, searching for comparisons and refining interpretation (Richards & Morse, 2012).

In vivo coding provides more insight on particular passages from transcripts and field notes worth retaining and eventually weaving into a script (Saldaña, 1999). The categories emerged from the patterns of the participants' actions, responses and their relationship to the performance. The four major categories that emerged were medical student, Ana, postures, and practice. These categories were further broken down using in vivo coding to thematically code the verbatim words of the participants. These codes were used as the title of the slides for each scene in the ethnodrama. In vivo coding adheres to the verbatim principle by using terms and concepts drawn from the words of the participants themselves. In vivo codes provide imagery, symbols, and metaphors for rich category, theme, and concept development, plus evocative content for arts-based interpretations of data (Saldaña, 2016). The ethnodrama were broken down into scenes that were generated based on participants' statements that were coded. Some of the scene titles include barriers, overwhelmed, breaking bad news, just to mention a few.

Dramaturgical coding was used to provide deeper insight to the participants' motives, conflicts, and attitudes, which according to Saldaña (2017), explore the intrapersonal and interpersonal participant experiences and actions in case studies, power

relationships, and the processes of human motives and agency. In dramaturgical analysis, the coded data is separated into six categories of character analysis by listing and reflecting on the objectives, conflicts/obstacles, tactics/strategies, attitudes, emotions and subtexts (Saldaña, 2016). The characters in the ethnodrama underwent these six categories of character analysis to provide a deep understanding of how humans in social action, reaction and interaction interpret and manage conflict. The objective might include not just what the participant-actor wants but what she wants other people to do. The attitudes, emotions and subtexts clued me into the internal perspectives of the participant-actor during these situations.

Dramaturgical analysis of social interaction is based on the assumption that social acts are staged, consciously or unconsciously, and thus embody all the elements found in enactments in the theatre. Plays on the theatre stage highlight all the elements of ordinary social life to present to an audience a new perspective on some aspect of social interaction. Thus, concepts used in theatre production can be turned back again for the analysis of the social behavior that they are designed to reflect (Hare, 2001).

The conscious and unconscious social acts in this study were depicted on stage by the actors and the spect-actors. This approach provides the contribution and the understanding of the unconscious -mind, body and emotion- to meaning-making in workplace learning. The spect-actors in this study are fourth year medical students about to begin their internship. The “new perspective” as stated by Hare, was provided by the spect-actors when they went up on stage to physically implement the changes to the scene

they believed would provide the preferred result in that scene. Dramaturgical analysis attuned me to the qualities, perspectives, and drives of the participants (Saldaña, 2016).

Visual Action

With visual action, since much of qualitative research analyzes participants in action, there are things to show. Thus, Forum theatre provided the platform through which the participants' showed the process by which meaning-making occurs in the learning process using their mind, body and emotion by taking the role of spect-actors. Saldaña (1999) suggests that theatre artist-educators serving as research collaborators have much to offer social science by exploring alternative modes of presentation and representation. The participants serving as my research collaborators in this study provided an opportunity to discover different means through which embodied learning can affect meaning-making. The merging of our ideas, using Forum theatre as a training tool created more inclusivity in the training process and opened our minds to certain areas that we had not considered due to our cultural biases and personal expectations. Their responses to the interview questions, their actions on stage, and the reasons behind these actions assisted in creating the visual action data included in the ethnodrama.

Verification — Adaptation

Participant voices from two or more individual interviews were inter-woven to offer triangulation by linking participant data through their supporting statements, highlighting disconfirming evidence from their contrast and juxtaposition, and/ or exhibiting collective story creation, through a multiplicity of perspectives (Saldaña, 2003). The conventions to insure a three-dimensional portrayal of a participant in the ethnodrama and the truth revelation in the script emanated from

- The interviews- what the participant reveals about his or her perceptions
- Field notes, journal entries, or memoranda- what the researcher observes, infers, and interprets from the participant in action
- Observations or interviews with the participants connected to the primary case study- perspectives about the primary participant and
- The research literature- what other scholars and theorists offer about the phenomenon under study (Saldaña, 1999).

I took these steps in the course of my analysis to ensure that the scenes created a sense of triangulation while providing a three-dimensional portrayal of the participants. I applied a hermeneutic approach to further interpret the results from the data.

Hermeneutics

The Greek term *hermeneuein*, meaning to interpret is the root from which the word hermeneutics is derived. For the Greeks, interpretation was the elucidation and explication of elusive sacred message and signs (Lawn, 2006). Heidegger introduced the concept of hermeneutics to philosophy placing it in the center of his analysis of existence in showing that interpretation is not an isolated activity of human beings but a basic structure of our experience of life (Dreyfus, 1984). The term hermeneutics refers to the interpretation of a given text, speech, or symbolic expression (such as art) Gjesdal, (2015). Thus, applying hermeneutics in this study aimed at interpreting the Forum theatre session alongside the ethnodrama generated as a result of the data collected.

Hermeneutics is conceived as the study of “the phenomenon of understanding and of the correct interpretation of what has been understood” (Ormiston & Schrift, 1990) and because man is constituted by the interpretation embodied in usage or custom, Heidegger

call's man's relation to the meaning of his practices a hermeneutic relation (Shapiro & Sica, 1984). Hermeneutic phenomenology is an interpretation of human being which demonstrates what interpretation is and why it is the proper method for studying human beings (Dreyfus, 1984). Art is inexhaustibly interpretable and as a symbol it is private revelation, not communal wisdom (Weinsheimer, 1985). In this study, participants contribute to the scenes on stage using their personal perspectives and experiences (private revelation) regarding that particular situation.

The circular nature of hermeneutic analysis uncovers the meaning in human practices. The hermeneutic circle refers to the fact that in interpreting a text, one must move back and forth between an overall interpretation and the details that a given reading lets stand out as significant (Dreyfus, 1984). Heidegger alludes to the concept of the hermeneutic circle saying that

There is... an opposition between the unity of the whole and the individual parts of the work, so that the task could be set in a twofold manner, namely to understand the unity of the whole by the individual parts and the value of the individual parts via the unity of the whole (Lawn, 1990 p.9).

This is a classic statement of the hermeneutic circle. In this study "the parts" are the scenes with the spectactors- mind, body and emotions while "the whole" is the ethnodrama itself. Thus, the whole is to be understood in relationship to the parts and the parts to the whole. These "parts" (different scenes) are understood in relation to the ethnodrama and the ethnodrama is understood in relation to the participants' actions in these scenes.

Art requires interpretation. When we interpret art, we interpret ourselves. Correlatively, in order to interpret ourselves, we need to interpret art, for not being present to ourselves, we need an-other through which to understand ourselves (Weinsheimer, 1985). Forum theatre serves as the other through which the participants in this study come to understand themselves by being present to themselves in the training. This understanding contributes to the interpretation of the ethnodrama generated from the data collected. Thus, whenever there is to be understanding there must be interpretation. Understanding is never immediate but always mediated by interpretation; and since this is always the case, understanding is indivisible from interpretation (Weinsheimer, 1985). This emphasizes the need to apply philosophical hermeneutics to this study. When seen from a hermeneutical perspective, many of our everyday practices take on a completely different aspect in this light. Philosophical hermeneutics has practical dimensions since it can modify attitudes and practices and offer new perspectives on activities and practices hitherto unexamined and taken for granted (Lawn, 2006; Ormiston & Schrifft, 1990). Applying philosophical hermeneutics to this study revealed modified attitudes and practices to work place training in adult education settings while offering new perspectives on activities and practices hitherto.

Chapter Summary

This chapter lays out the approach I took to analyze the data collected on this study. It also identifies the similarities in the steps between ethnodrama and qualitative research. I explained how I came up with the different Scenes in the ethnodrama. Through the application of in vivo coding and dramaturgical analysis, I generated the ethnodrama from the data collected. In the bid to arrive at the interpretation of the data,

the application of a hermeneutic approach revealed the truths of the participants by focusing on the contributions of the mind, body and emotion to meaning-making. The next chapter provides the ethnodrama, which for the purpose of this study is defined as the representation of data collected. I playwrote with the data (Saldaña, 2003), generating the ethnodrama laying emphasis on the “juicy stuff” (Saldaña,1998).

IV. THE PERFORMANCE

This chapter brings together the data collected in this study in the form of a play. The data collected include field notes, observations, interviews, transcribed video recordings, video recordings, and reflections. The chapter starts off with a synopsis of the Forum theatre presentation that was used for the training. This is followed by the definition of the characters in the play. The barriers to health and engagement in care for the patient Ana are also identified in relation to how they affect the patient in the Forum theatre presentation. The next phase lays out the global health scene sequence. This explains what was done from scene to scene in the Forum theatre presentation for the global health training. After the scene to scene description comes the play.

The play is divided into three major parts which include the Prologue, the scenes, and the Epilogue. The prologue looks at preparation and expectations for the training. The division of the Acts is based on the characters in the play that generate actions amongst the training participants. There are four Acts in the play including an epilogue and a prologue. The first scene focuses on the medical student who is the protagonist of the play. The second scene focuses on Ana the medical patient in the play. The third focuses on specific changes that have been made to postures of characters in the play. The epilogue addresses the practitioners and trainer's perspective on expectations and success of the training.

Since this play is based on a medical situation it is important to first define medical terms used in the play. These terms are as follows:

Medical Terminologies Defined

HIV: Human Immunodeficiency Virus

ART: Antiretroviral therapy

CD4 count indicates your immune status and treatment efficacy. It measures the level of CD4 helper Tcells.

CD4 nadir (the lowest point to which the CD4 count has dropped)

Viral loads measures the concentration of virus in the blood also known as viral burden

Low nadir CD4 count has been identified as an independent predictor of several premature age related co-morbidities in HIV infected individuals

HIV-1 RNA: The measurement of plasma levels (viral load) provides quantitative measurement of viremia and is used in conjunction with CD4 + T-cell counts. The base line (pretreatment) HIV RNA level combined with the baseline CD4 count, predicts progression to AIDS and death. Increasing levels may be due to disease progression, failed antiretroviral therapy, suboptimal adherence to treatment, immunizations, or occasionally, other active infections (tuberculosis, pneumococcal pneumonia).

Decreasing levels indicate therapeutic response and improved clinical outcome.

LMIC: Low and Middle-income country

NGO: Non-Governmental Organization

Synopsis

Ana is a 26-year old woman with HIV living outside of Baní, Dominican Republic (DR) (red arrow). She receives HIV care at a Non-Governmental Organization (NGO) -run adult HIV treatment center in Santo Domingo, DR (purple arrow). She has been on antiretroviral therapy for a year and a half, and travels into clinic every 30 days to pick up

her medications. Ana, her 2-year-old uninfected daughter stay with her mother when she comes to the clinic.



Figure 2: Map of The Dominican Republic

On her initial visit, her CD4 nadir was 60 cells/mm³ prior to starting first line antiretroviral therapy (ART) with efavirenz, zidovudine and lamivudine. She has been on therapy for 16 months, and has never showed up for laboratory testing until this month. Her new CD4 is now 90 cells/mm³ and her HIV-1 RNA plasma viral load is 95,000 copies/ml.

The clinic physician is concerned that Ana has developed resistance to her antiretroviral therapy (ART). The nurse suspects that Ana just isn't taking her medications. Both the clinic physician and the nurse are frustrated that the patient won't follow their advice to seek care in Bani, rather than traveling all the way to Santo Domingo. In the middle of all this is a medical student from the U.S on a two-week rotation, is assigned to shadow the clinic physician.

Characters

Christopher (Medical Student): Has been in the Dominican Republic for a week, shadowing physicians. He has a fairly good rapport with the clinic physician. He is fairly knowledgeable about HIV care and adherence counseling, and he understands the importance of Ana taking her medicine.

Ana: Is very reluctant to reveal her relationship with her boyfriend, her engagement in commercial sex work, and is ashamed of her inability to pay for transportation and her HIV treatment. She is terrified that people in her small hometown will discover her diagnosis and ostracize her—a very legitimate concern based on her experience.

Doctor: Frustrated because Ana is not communicative with her and is failing treatment. She doesn't think Ana understands that she will die if her CD4 cell count remains this low. She wants Ana to get care in the clinic in Baní, and is angry that Ana won't take her advice.

Nurse: Knows more about Ana because he has time to talk to her. He suspects she isn't taking her medications regularly.

Mama (Ana's Mom): Cares deeply for Ana and is ashamed that her daughter has HIV. This is a reflection of her parenting, and she's embarrassed that her daughter is "andando en la calle" meaning (*walking the streets*)

Enrique (Ana's Boyfriend): Is mistrustful of all physicians and medicine in general. He does not want people interfering with him, his girlfriend, or his relationship. Enrique believes that he can tell who has AIDS because they are really skinny and sick looking and generally die right away. This is not something that could ever happen to him, and he hates condoms because they are too tight on him.

Gossipy neighbor in Baní: Suspects that Ana might be a commercial sex worker, and thinks her boyfriend is “no good.” Generally, likes to talk about anything interesting in Bani, and share it with everyone.

Identified barriers to Ana’s health and engagement include:

- The cost of transportation from Baní to Santo Domingo has tripled over the past year. Ana does not have a regular income, having lost her job working in a market stand selling clothes. The HIV treatment program rules dictate that Ana cannot receive more than a 30-day supply of medication at a time, so she must pay for travel to Santo Domingo every 30 days.
- Ana has been encouraged by her providers to get HIV care and pick up her medications in the new HIV treatment center in Baní, but Ana does not want people in her hometown to know she has HIV. This is frustrating for her providers, who think that she is failing treatment because she never shows up on time to pick up her medications.
- Ana’s relationship with her mother is close but difficult, and both she and her mom feel a lot of guilt about the fact that she has HIV. When Ana comes in to Santo Domingo for care, they both work to hide her HIV diagnosis and the motivation for her visits.
- Ana probably supplements her income with commercial sex work, though she is very hesitant to admit this. Her “boyfriend,” with whom she has a stormy relationship, also serves as her pimp. They do not always use condoms.

Global Health Scene Sequence

- Dr. Garcia, nurse and medical student (Christopher briefing): In this scene the nurse introduces Christopher from the United States to Dr. Garcia. The doctor speaks to the medical student welcoming him to the hospital, but informs them that she is on her way home. She just saw 40 patients and is now going over to her other clinic. In this clinic, they treat about 800 people a day and about 40 patients each morning. Christopher is quite surprised at this number. Dr. Garcia asks if the medical student is familiar with HIV care, he responds in the affirmative. Then Dr. Garcia informs Christopher that they will be expecting Ana the next day. She expresses that the patient should have AIDS at this point since her CD4 count has gone up to 90 after 16 months of treatment. The doctor believes that her viral load is not suppressed because she is not taking her medications. The doctor wants Christopher to convince Ana to take her meds. Then the doctor asks Christopher “how is your Spanish?” and he replies, “not great”. The doctor tells him that Juan, the nurse, can help him translate.
- Cut to a scene with Ana’s mother, the gossip neighbor and Ana in Baní the village. The neighbor comes in early in the morning telling the mother that people are talking about how skinny Ana is getting. Her mother says it is the current trend with young girls trying to stay slim. Ana comes in at this point and after greeting both mother and gossip neighbor settles down to eat the breakfast prepared by her mother. The gossip neighbor begins to nag her about how skinny she is and sights a rash on her arm and Ana hurriedly brushes it off as an allergic reaction. Her mother insists it must be a bug bite. Enrique comes in with frijoles

for mama. He is there to take Ana to the hospital for her appointment but glamorizes the trip by saying he is taking her into town. He rushes off with Ana following in a subdued manner and her mother pleading that they get some breakfast on their way into town since Ana did not eat her breakfast. At their departure, the gossipy neighbor expresses her dislike and distrust of Enrique who she believes is a sketchy character. Mama responds by stating that he is a nice guy who always brings something when he comes around. Also, she is very glad that her daughter has a boyfriend. She ends the scene saying, “I’m sure she is fine” Although her words sound positive, she sounds as though she is trying to hide something.

- Cut Back to Doctor Garcia, Juan and Christopher: Juan, the nurse welcomes Ana and Enrique with familiarity and directs them to the waiting room while he informs them that he is going to get the doctor. Juan meets Christopher on the corridor. Dr. Garcia, coming towards them, speaks hurriedly into her phone about the medications to be given to a patient. She insists that they call her back right after administering the medication. At the end of her phone conversation Christopher informs her that Ana has arrived, and he expresses a desire to speak with Dr. Garcia about Ana’s file he reviewed. Dr. Garcia cuts him off mid-speech expressing that she wants Ana to start taking her meds in the HIV clinic in Baní. She also believes that since her CD4 is 90, it means that Ana has a 50% chance of mortality in the next 6 months. “Tell her she is going to die if she does not take her medications.” Christopher asks, “you want me to tell her she’s going to die”? ... (*Christopher sounding concerned says*) Okay. Dr. Garcia replies saying, “She

is 26, and she feels absolutely invulnerable and thinks she can do whatever, but she is not. She is going to die. She is all over the place. She does not really know. Just let her know that it's very serious. She is going to die if she doesn't take care of that. Go talk to her." At this point Christopher realizes that he is to go into the examination room alone and break this news to Ana without the attending, Dr. Garcia. Dr. Garcia explains the reason for her absence stating that she has three other patients to see, but she promises to circle back and talk to Ana about her meds after seeing them. As they are about to go in to see Ana, Juan begins to explain Ana's real situation since he has been seeing her for over a year, but Christopher dismisses him saying he will simply focus on what Dr. Garcia instructed.

- Cut to scene with Ana and Enrique in the examination room: Christopher and Juan come in exchanging pleasantries. Juan introduces Christopher as a medical student from the United States. Christopher informs her that she has AIDS and she has not been taking her meds, but Enrique insists that she has been taking her meds. Christopher inquires who he is and he identifies himself as her boyfriend asking in turn who Christopher is. Enrique is upset and asks Juan for Dr. Garcia. Christopher informs Ana that she will die in 6 months based on her CD4 count and HIV1 RNA plasma viral load numbers. She needs to start taking her meds. Ana appears shocked but hardly says anything. Enrique insists that she has been taking her meds and all they want is their refill so they can get going. His phone rings and he excuses himself to receive the call. Upon his departure, Juan sits with Ana to find out what is really going on. They discover that Ana is pregnant and

that is why she has not been taking her drugs. Christopher and Juan assure her that taking her meds will prevent her baby from contracting HIV. When Enrique returns, Christopher suggests they go to the HIV clinic in Baní. They both refuse. Enrique states that such an action will be bad for business because they talk too much in Baní. Christopher asks what kind of business he is referring to, but Enrique insists it is none of his business. Dr. Garcia rushes into the room and greets Ana hurriedly reiterating that she needs to take her meds. She insists Ana should start going to the clinic in Baní. Turning to Christopher, Dr. Garcia drags him out for an interesting case of Chikungunya (Zika). The scene ends with Juan going to get the refills for Ana.

- Cut to scene with Christopher standing directly facing the audience: Christopher approaches the audience and soliloquizes on why he came there and why he wants to be in Medicine(vision); what he wants to do / what-why are the obstacles(exposition); and what it means to him when he can't help a patient for whatever reasons(stakes). The scene ends with him in a very frustrated state.
- When Christopher ends his monologue, the Forum process begins.

Since this is a presentation of the data collected in the form of a play, it is important to first define the theatre stage direction terminologies to give a better understanding of the movements and placements of the actors on the stage. This allows readers to have a clearer picture and understanding of the play.

Theatre Stage Directions Terminologies Defined

USR: Up stage right

USL: Up stage left

DSR: Down stage right

DSL: Down stage left

DSC: Down stage centre

CSC: Centre stage centre

CSR: Centre stage right

CSL: Centre stage left

Slide: This is a projected screen that serves as the back drop for that scene highlighting the key phrases from the narrative in that scene for the audience which serve as the themes in those scenes.

Cast List

Dr. Garcia: A female between 40-45 years. She has a habit of speaking very fast. She seems to always be in a hurry to meet up with someone or something. She is from the Dominican Republic

Christopher: He is a third year American medical student in Santo Domingo for an internship. He is between 25-28 years. He is about 6'2" in height. He pronounces the word Baní and Bunny. He is sometimes referred to as intern or medical student in the play.

CJ: This is a third-year medical student who acts in the play

Ana: She is between 29-31 years. She speaks quietly, almost as though afraid to be heard. She always has a smile on her face when talking to the medical practitioners.

Juan: He is the nurse. This is a male between 30-33 years. He is soft spoken. He has a friendly demeanor

Joker/Kat: This is a female between 56-65 years. She is the Forum theatre practitioner. She is referred to as Joker in the play. She has a very friendly demeanor and a booming voice that she uses to communicate with the spect-actors.

John: He is a fourth-year medical student between 25-28 years with a friendly demeanor.

Zoe: She is a fourth-year medical student between 26-29 years with a reserved demeanor.

Shannon: She is a fourth-year medical student between 24-28 years with a friendly demeanor. She smiles frequently.

Sarah: She is a fourth-year medical student between 26-28 years. She has a friendly demeanor.

Morgan: She is a fourth-year medical student between 26-29 years. She has a friendly demeanor.

Teresa: She is a fourth-year medical student between 26-29 years. She has a reserved demeanor. She speaks softly.

Mumini: He is between 36-40 years. He is a visiting medical student in the class. He is from Burkina Faso.

Enrique: He is between 32-38 years. He seems to be in a hurry both in speech and movement. He is very fidgety and does not trust the medical intern.

Gossipy neighbor: This is a female between the ages of 48-52. She has a shrill voice.

Mama: She is between 51-55 years. She is soft spoken. She has a friendly demeanor

The play which you are about to read brings together the data collected in this study.

They include field notes, observations, interviews, transcribed video recordings, video recordings, and reflections. In constructing the play, there was a constant reading and re-reading of the written data, listening to recordings of audio interviews, and watching of video recordings to arrive at the “juicy stuff” (Saldaña,1998) in the data collected. As a result, the dialogues, and monologues in this play are direct quotes from transcribed data.

PLAY TITLE: THE DILEMMA

Prologue

Lights shine on a group of people center stage on stage in a circle, chatting casually while stretching and moving their bodies in different directions. There are pictures on the wall of different guilds of nursing. There are bookshelves against the walls to the left and right side of the stage that contain medical paraphernalia. Those on the stage include Juan, Christopher, Enrique, Ana, Mother, Gossipy neighbor, and Dr. Garcia in a circle. Within the circle is the Joker who instructs the group to carry out different activities using different parts of their bodies. The atmosphere is very cool and serene with only their voices being heard. There are two rows of chairs DSR and two rows of chairs DSL facing the group of people.

Joker: Okay, let everyone stretch a little bit. Stretch all the way up to the ceiling, *(Everyone in the circle is doing as the facilitator requests)* up, yes and touch your toes. All the way up, touch the ceiling, wave your hands, and then drop them down. All right, take a deep breath in and out. Now I want you to walk around in different directions *(they begin walking in different directions on the stage)*. Now add a different action to that walk and if I call your name you show us your style of walking and we will imitate you. Okay CJ show us your style *(CJ walks from side to side and everyone begins to walk from side to side)*. Now for the fun part, everybody take their right hand and make a circle. It can go inside or outside, it doesn't matter *(The people in the circle make these hand movements as directed)* Very good, one more. Now make a cross with your left hand, down and across. Down, or a plus sign maybe *(Group members begin to make the*

cross sign with their other hand) Now do them both together. Don't feel bad (*laughing*), nobody can do it, but try. (*Laughter breaks out all around the room as they do the actions suggested by the facilitator*) One more try, okay.

Lights dim on them and lights shine on Dr. Taylor DSR

Slide: Expecting

Dr. Taylor: What I am expecting from this training is for them to sort of see this situation as it unfolds and think about how they would respond to that. Hopefully, in interacting with it, and acting it out, they then are more prepared when something like this happens to them; to engage and feel less powerless and more ready to do the right thing, if possible, and to realize that there is no right answer. That's, I think, the nice thing about Forum theatre. It allows you to sort of embrace the ambiguity of how all this works. The scenario really lends to thinking about what your role is as a medical student abroad. The scenario is from an ethnography that I did in the Dominican Republic. It's a real live scenario. I think it's great for the students to see how medical students can sort of get trapped in these dilemmas. It is applicable to the U.S too. I mean it's hierarchy and things happening that you don't necessarily think are the right things to happen. How do you deal with that as a medical student who has very little power, in terms of the structure, but a lot of power in terms of working in a low and middle-income country (**LMIC**) Forum theatre will apply really well to the global health course because we want to get them up, and

interacting, and on their feet as quickly as possible (*everyone nodding in agreement*).

CJ: I think that there's power in actually stepping into those shoes and playing out the part, and forcing your body and voice to commit to those values and being empathetic to patients... exploring social determinants of health and all of that. I think while you may feel stupid doing it, it sticks with people. You remember it far more than just another power point lecture. I think there's probably some subconscious just reaffirmation at least of, "Yeah, this is the kind of doctor that I want to or the kind of doctor I don't want to be." I think coming into it my expectations are always very much so dependent on what the group of students will be like. Whether they're going to jump in and be participatory or whether they're more stand-offish, just wanting to talk about it

Joker: Well, it's very funny for me to have an expectation on something that's so spur of the moment because nothing is memorized in this. That's the beauty of it. You don't memorize ... In this instance, we do because there are particular conflicts we need to teach these students. One, they're not going to always get their way. Two, they have to have respect, and they have to be able to take that instruction from their mentor. We can't just let them go off half loaded. We want to instill with them that they have a voice. How do you use that voice? No, they don't have to ask for permission every time, but is it something that they think they can resolve? Then bring people into that circle. Here's what I think. This is the

voice in my head. Will this work to make a change? That's what Forum theatre does. It gives them the opportunity to say, "I think it should be this way. Here's what would make this situation right." They have an idea. Don't squash their altruism. Allow them to be students and learn, but please let them keep those ethical high standards that hopefully they were born with and were raised with, and allow them through theatre to change the world. It can be done. Okay so we all know that tomorrow something is going to happen before we perform, so let's just get into what we are doing for this right now and then we'll figure it out. *The circle begins to break up with people setting the stage for rehearsals, lights fade out.*

THE MEDICAL STUDENT

Lights come on to show Juan and Christopher at the corridor scene awaiting Dr.

Garcia to get off her phone call and join them to go see Ana. This is the scene where Christopher is instructed to inform the patient (Ana) that she is going to die. They are CSC with ten medical student trainees seated DSL. These students are intensely watching the performance with occasional smiles on their faces in reaction to the actions and words they see and hear being portrayed on stage.

Dr. Garcia: *(Talking hurriedly on the phone and walking very hurriedly to Juan and CJ)* Two nebulizers... give two nebulizers. Remember he's very small so don't overdose him, and call me back. Look, if he's really having trouble breathing, you've got to give them nebulizers now. No now. Okay, then call me back and tell me what his peak flow is. *(Speaking to Juan and Christopher)* Oh my gosh, the clinic is crazy

Christopher: Hi again Doctor Garcia.

Dr. Garcia: Hi Charles, how are you?

Christopher: Christopher.

Dr. Garcia: Christopher, yes. *(Some students laugh when Dr. Garcia erroneously calls Christopher Charles)*

Juan: Morning.

Dr. Garcia: Hi.

Christopher: Ana's here waiting. She just got in.

Dr. Garcia: She made it. Okay great

Christopher: I read up on Ana last night.

Dr. Garcia: Outstanding

Christopher: I think I'm pretty familiar with her case. I'm ready to go talk to her with you.

Dr. Garcia: Okay, well I actually have a couple of other patients to see. What I was gonna do is send you in to talk to her.

Christopher: *(Surprised)* Oh!

Dr. Garcia: To talk to her

Christopher: *(Slightly raised voice in panic)* By myself?

Dr. Garcia: Yes, well you can go with Juan, Juan will help. He will help with the translation and all that. You read about her, right?

Christopher: Yeah.

Dr. Garcia: Generally, we know from her viral load that she's not taking her medications.

Christopher: Exactly.

Dr. Garcia: So I think you need to do two things, really. We have two main messages for her. We want her to transfer her care to Baní, there's now an HIV clinic there.

Christopher: Oh wonderful, perfect.

Dr. Garcia: It's in her home town. It will be much easier for her to get all of- which is...

Christopher: *(Cutting her off)* She should just start going to that one.

Dr. Garcia: Exactly. Yes, I'm glad we're on the same page with that. She should get all of her care there. The other thing is that with her CD4 as low as it is, do

you have a sense for why? Could you just ask her why? Why is this happening to her? Why is she not taking her meds?

Christopher: It's hard.

Dr. Garcia: I think maybe she just doesn't get it. She's 26, she feels like she's immortal, and she's not taking her meds. She really needs to understand that with a CD4 of 90, she has a 50% chance of mortality in 6 months. Tell her that. Let her know. I tried everything with her.

Christopher: *(Looking up from the notes he is taking, looking squarely at Dr. Garcia in almost doubt and shock)* You want me to-

Dr. Garcia: *(In a matter of fact manner).* Tell her, if she doesn't take her meds, she's gonna die

Christopher: *(Asking with a little bit of confusion on his face and distress in his voice)* You want me to tell her she's gonna die? ...

Dr. Garcia: Yes, let her know, if she doesn't take her meds. Then she'll take her meds. Tell her that if she doesn't take her meds she's gonna die, okay?

Christopher: *(A little reluctantly)* All right

Dr. Garcia: I'm gonna go see the other three patients I have, and then I'll circle back once you've talked to her and gotten all this out with her.

Christopher: All right, that sounds good. Thanks Doctor Garcia.

At this point one of the students in the audience speaks up

Sarah: I wanna change something the clinical director said *(Everyone on stage pauses)*

Joker: Sure. Do you wanna back up to there?

Sarah: Sure, just to that part where she's telling the med student.

Joker: Sure, sure. We can bring in the clinical director. (*Asking Sarah*) Telling him what she wants him to say?

Sarah: Telling him that the patient, she's gonna die. (*Replying to the Joker, Sarah stands up and goes to the stage to take the position of Dr. Garcia in the scene*) Over here? (*Asking the Joker if she is in the right position physically for the scene*)

Juan: You're now the clinical director.

Sarah: (*Laughing a bit nervously as she says*) Oh my gosh

Christopher: Hi, Doctor Garcia. It's Christopher again, it's great to work with you.

Sarah: Nice to see you. Okay, we already discussed the case.

Christopher: Yeah, I read up on Ana's case.

Sarah: Okay. Her white count or CD4 is like 90. I want you to figure out why she's not taking her meds.

Christopher: Okay.

Sarah: Also, she needs to understand that this number is really low. She has a 50% chance of dying in six months. Maybe you shouldn't tell her right off the bat.

Christopher: Do you have any suggestions of how I could talk to her about that?

Sarah: I want you more to find out. Sit down with her and find out why she's not taking her meds.

Christopher: All right, I'll ask her about that. Thanks Doctor Garcia. (*Sarah begins to return to her seat*)

Joker: Why did you take Dr. Garcia's position Sarah?

Slide: Responsibility

Sarah: I guess my point with her is, (*Sits in her chair*) I understand she's busy and she has to go see a bunch of other patients, however, you need to find out what's going on with this patient, why isn't she improving? Why isn't she taking her pills? I thought she should maybe narrow down the medical student's responsibilities to a task that's going to take 10-15 minutes, hopefully longer. Also, I don't think it's appropriate for the physician to put a medical student in charge of, say, a big diagnosis, a big, "You're going to die." That's something that I think you shouldn't ask a student to be doing in the first place. I understand sometimes we're thrown into telling a patient, "Hey, you might have diabetes," or things like that. I don't know how to describe it, but there's a line that gets crossed. I also think, "Okay, it's the attending physician's responsibility to tell the diagnosis, or at least give that big bad news; not the student's responsibility. If you want the student to be helpful, instead of slamming a billion tasks, let's ask the student to give me this piece of information, use your 10-15 minutes in order to get it.

Mumini: (*Speaking from his chair*) I have lived this scenario a thousand times in my country where your boss comes and talks very fast, and he even won't repeat himself. You are supposed to register everything and do everything he told you to do. He has no time. Sometimes he will tell you to say things to your patient that you don't think you can. You're not prepared to say

that. Imagine the director told the intern to tell the patient, "You will die if you don't take your medicine." That's a huge responsibility. That's one, the first thing. According to my education and our cultural way of living, your professor is your professor. He is your elder and you can't just reply to him in a bad way.

Zoe: *(Speaking from her chair)* I mean what the attending says goes, really, because he is the doctor, you are not. I mean, I would just ask questions to try to figure out why they were doing what they were doing.

Teresa: I would have, like, I knew she was busy, and running around, and taking phone calls, but it would have been nice to see her say, "Hey Chris, let's go into the room together." Actually have her debrief with Chris and be like, "This is how you break bad news. Let's discuss it. What would you say?" Then have a brief discussion about how to break bad news. Then go in there to the room, with him, to see the patient. Have her do the bad news delivery in an empathic way and then leave the room with him. Then talk about it again and say, "What do you think about the whole scenario? Would you have changed anything? Is this what you would have done?" Sort of discussing it through the entire process. I realize that takes a lot of time. I think, yeah, when you're a teacher and you want to be a good teacher, it just takes a lot of time. I think that would have been good in delivering bad news.

Slide: Breaking Bad News

Joker: We're going to run the scene. Do you wanna see the scene all through one more time, or just go? (*Some nod in agreement while some verbally agree to see it run again*) Okay, let's go with it. This is your opportunity, if at any time that you can make better, say "stop".

(The scene begins again from the clinic scene where Dr. Garcia meets Juan and Christopher)

Dr. Garcia: (*Talking hurriedly on the phone and walking very hurriedly to Juan and CJ*) Two nebulizers... give two nebulizers. Remember he's very small so don't overdose him, and call me back. Look, if he's really having trouble breathing, you've got to give them nebulizers now. No now. Okay, then call me back and tell me what his peak flow is. Oh my gosh, the clinic is crazy (*speaking to Juan and Christopher*)

Christopher: Hi again Doctor Garcia.

Dr. Garcia: Hi Charles, how are you?

Christopher: Christopher.

Dr. Garcia: Christopher, yes. (*Some students still smile at Dr. Garcia calling Christopher Charles*)

Juan: Morning.

Dr. Garcia: Hi.

Christopher: Ana's here waiting. She just got in.

Dr. Garcia: She made it. Okay great

Christopher: I read up on Ana last night.

Dr. Garcia: Outstanding.

Christopher: I think I'm pretty familiar with her case. I'm ready to go talk to her with you.

Dr. Garcia: Okay, well I actually have a couple of other patients to see. What I was gonna do is send you in to talk to her.

Christopher: *(Surprised)* Oh!

Dr. Garcia: To talk to her

Christopher: *(Slightly raised voice in panic)* By myself?

Dr. Garcia: Yes, well you can go with Juan. Juan will help. He will help with the translation and all that. You read about her, right?

Christopher: Yeah.

Dr. Garcia: Generally, we know from her viral load that she's not taking her medications.

Christopher: Exactly.

Dr. Garcia: So I think you need to do two things, really. We have two main messages for her. We want her to transfer her care to Baní, there's now an HIV clinic there.

Christopher: Oh wonderful, perfect.

Dr. Garcia: It's in her home town. It will be much easier for her to get all of- which is...

Christopher: *(Cutting her off)* She should just start going to that one.

Dr. Garcia: Exactly. Yes, I'm glad we're on the same page with that. She should get all of her care there. The other thing is that with her CD4 as low as it is, do

you have a sense for why? Could you just ask her why? Why is this happening to her, why is she not taking her meds?

Christopher: It's hard.

Dr. Garcia: I think maybe she just doesn't get it. She's 26, she feels like she's immortal, and she's not taking her meds. She really needs to understand that with a CD4 of 90, she has a 50% mortality in 6 months. Tell her that. Let her know. I tried everything with her.

Christopher: *(Looking up from the notes he is taking, looking squarely at Dr. Garcia in almost doubt and shock)* You want me to...

Dr. Garcia: *(Cutting him off)* Tell her, if she doesn't take her meds she's gonna die.

Christopher: *(Asking with a little bit of confusion on his face and distress in his voice)* You want me to tell her she's gonna die

Dr. Garcia: Yes, let her know, if she doesn't take her meds. Then she'll take her meds. Tell her that if she doesn't take her meds she's gonna die, okay?

Christopher: Alright

(Dr. Garcia departs to go see the three other patients. Christopher gathers the notes he has taken on Ana the patient preparing to go into the examination room with Juan)

Juan: *(Trying to speak to Christopher before they get into the examination room to see Ana)* Yeah, this case is pretty complicated

Christopher: Yeah, it seems like it.

Juan: There's a lot of issues that she's having. I think transferring to Baní is gonna be a little bit challenging for her...

Christopher: *(Dismissively and collects the patient file from Juan)* I think I've read up on it. I'm gonna try to say what Doctor Garcia wanted me to say

Juan: Be careful with... *(brief pause)*. Okay.

Mumini: Stop.

Joker: We have a stop. Okay, go. Who are you going to replace?

Mumini: *(Pointing at Christopher, Mumini walks over to the stage and replaces Christopher on stage with himself)* Him

Juan: Great, so I think we can go on in there. I wanted to let you know. The case... is very complicated. There's good reasons why she does not want to go to Baní. I think we have to be very sensitive there. I would be very careful about how you're going to tell her about taking her medicines, and what the impact could be. These are gentle things; we can't just tell people they're going to die.

Mumini: That's true. How familiar are you with her?

Juan: We've been seeing her now for almost 2 years, so I see her every day, I mean every time she comes.

Mumini: I don't speak Spanish, so could you help me?

Juan: Of course, I'd be happy to. Is there anything else that I could tell you before we go in?

Mumini: No. Can you tell her that I want to go through a physical examination?

Juan: Sure, shall we?

Mumini: Yeah.

Juan: I'll let you take this. (*Hands Mumini the patients' file and they go into the examination room*) Morning, morning. (*Asking the Joker*) Do you want me to keep going?

Joker: Wonderful. Let's stop right there. (*Asks Juan*) What did you feel about that change? Juan: That he wanted to first hear something that I had to say.

Joker: It validated you.

Juan: (*Affirmative*) Mm-hmm

Joker: Do you think it would make a difference?

Juan: Yeah. I totally was willing to then actually talk to him. I even offered to give him more information than he was asking for.

Joker: What did you all think?

Morgan: It was much calmer.

Joker: Calmer, wasn't it? Yeah. Anything else?

Sarah: I like that he asked, "Can we talk to the boyfriend, say we're going to run through a physical exam?" Just to better prepare himself...

Mumini: So I felt that Christopher can play a key role because the doctor was giving up. I feel Forum theatre engages people emotionally. I felt the nurse is angry at the intern. He just felt the intern is not listening enough to him. So I felt that it's important if I replace the intern and I listen to the nurse, I can change things in this scenario. Christopher will be directly in contact with Ana. So to make the change, I felt that in replacing the medical student, I will be in contact with Ana and then I can make a difference.

John: I feel like the nurse, he seems like he is a real people person. He could talk to everyone. He could help out everybody. I feel like I personally am the type of person who can go up and talk to anyone. I really, really try to go out of my way to help people often times, even maybe when the people don't need it

Morgan: I feel like I've seen this situation in real life, not quite like that, but it was like my third year and I was in the cancer clinic and I had a resident that was super stressed out and had to see a bajillion patients and goes in and basically has to break this news to this old lady that she has pancreatic cancer and this is like my first rotation I had had like zero patient interaction, I'm like, "Oh my gosh, this is going to be so great!" And I'm just following him in there and he's like, "Oh, well..." something to the effect of, "You have stage II pancreatic cancer. I can't tell you much more about this. The attending physician is going to come in and explain more about it." This lady is sitting here, she's like seventy with her two kids, and he just leaves after spending like thirty seconds in there. I was like, "Wait, what? That's even shocking for me! And you didn't even ... I'm not the one who has cancer." I was like I ... "What do I do?" This lady is crying and her kids are like, "Oh my gosh, what do we do? What do we do? You just got told you had cancer." And of course I don't have any knowledge or anything. I have no training about what to do in this situation, but I just pulled up a stool and I was like, "Tell me what you feel."

Shannon: I had to counsel family members on my patient, who got admitted to the ICU. He was in his 90's, and we knew it wasn't going to end well, but the wife would always ask me, you know, "Is he going to be okay?" She was very kind of separated from what was actually going on, and so, every time she asked me that, I was like, that was, it was kind of one of those moments you wish you'd practiced a great response to that question, and afterwards, I did. Once she would ask me that day after day, it was like, "You know what? This is a great time to be with him," you know, "We don't know what's going to happen, but his symptoms are very severe. You need to hold his hand, you need to talk to him, say everything you want to say." (*Inhales deeply*)

Sarah: I had to tell someone they were diabetic, that wasn't fun. It's a devastating illness. The patient was scared that she might have it. This is actually almost a global health trip. It was in Laredo. The whole point was to serve the communities that are right there on the border. There was this woman that was like, "Oh my gosh, everyone in my family has diabetes. I'm worried. I'm coming here to get screened." It turned out her blood sugar was really high. I was a second-year student. It was like, "Okay, this was her blood glucose value. Do I tell her like that?" We had patients in a line. We were sitting behind tables. It was almost like a factory; a conveyor belt thing. I was in charge of poking people and getting their blood glucose. When I saw the number, I told her it was really really high. I was like, "Okay ..." I don't know, she communicated to me, "Oh my gosh, I'm really

worried about this." I think at the time, back then I was freaking out like, "Oh my gosh, this is really high." I told her, "Okay, your blood sugar is really high." I wasn't sure what else I was supposed to say at the time...

Mumini: They don't teach us the importance of empathy, the importance of caring for our patients. That's something we miss as healthcare professionals. Usually when you talk about it, they don't validate it because it's not a scientific way of speaking. When I say you need to love your patient, people will say, "He is weird. He's like crazy. What is the scientific evidence of what he's saying?"

Teresa: I remember in the emergency room this guy came in with a probable stroke. He was having neurological symptoms. Parts of his body were numb. I had to tell him, "This could potentially be permanent." I sat down with him, asked him what his perception of what was going on, and he's like, "I don't know. This all started a couple days ago. I didn't come in because I thought it would go away, but it didn't, so now I'm here." It was so bad. I usually start off with explaining to him what his symptoms mean and how that relates to how a stroke happens. Then I essentially told him, "We may not have all the information now. We're still waiting on your scans." Then he straight up asked me, "Is this a permanent thing?" I said, "potentially, but we will need more information." He was very emotional. I think he was intoxicated at the time, so he was also very disappointed at the news, that I couldn't just be like, "No, nothing's wrong."

Zoe: It is quite challenging breaking bad news. The only time that I can think that I was like the main person I wasn't really directing the conversation, but I was more translating for my resident who was talking to a pregnant patient. We were talking about the contingencies and all the different possibilities and the different things that could go wrong, what might happen, what we might have to do, asking if she understood; and would she want us to try and resuscitate her baby if it was born prematurely, because you have to go into all the details, and all that kind of stuff. Especially like this woman had had multiple times that she delivered early, prematurely, and it was really hard for her, kind of revisiting all of that. She was very tough. Yeah, there were multiple times during that service, I mean there are times that you have to handle bad news, but ultimately, it's one of those things that you just tell them everything that you know and all the options, and they kind of have to pick it, and then you kind of have to accept it, whatever they pick. That's just how that works.

Mumini: I once received a girl who was 12 years old, very brilliant, but with edema. She had trouble with breathing and our exams showed that she had heart problems with aortic valves. Through a different examination, we saw that she had problem born from carrier, tooth decay. It leads to problems. It's just because she didn't know how to brush her teeth, when to brush them, with what to brush them. So she got this problem and she had to go through heart surgery that we didn't have and we still don't have in Burkina. Her parents had to pay 50,000 USD to get her to another country

and be treated. It's a lot of money and her parents didn't have it. And she always asked me, "Doctor, will you be able to treat me?" That's a question, you know the answer is no, but you can't say it. So, I would say, "well, you know, we'll do our best. Slowly, we lost her. She died at the end of the day, but we always smile and hope that someone will do a miracle.

Unfortunately, nobody was able to do it (*Everyone is silent and looking slightly reflective*).

Joker: Do you wanna run it again? You can call out stop. Does anybody have a burning desire at a certain place that we've gone to at this point, before they go into the exam room, that you would want to change, or feel you can make it better? (*Silence as some spect-actors shake their heads in the negative*) Okay, run from when you go in the exam then.

Slide: Potential Allies

Ana is seated while Enrique walks around the examination room as though in a hurry to leave. Enrique occasionally glances at his wristwatch, taps Ana on the shoulder and glares at her while pointing at his wristwatch. Ana, whose head is bowed down, looks up at Enrique when tapped on her shoulder. She looks apologetically towards Enrique, and pleads with him to sit for a while before Juan and Dr. Garcia arrive. He sits for a while then abruptly stands up, impatiently pacing the room again, all the while looking Ana over as if inspecting her, as though expecting to find something amiss (This is carried out non-verbally). He uses his fingers to search the bunched up hair on Ana's head like product he intends to sell. All this occurs while Ana has her head bowed

down. Ana places her hands under her thighs, sitting on them. Her feet are folded at the ankles and tucked away neatly beneath her chair.

Christopher: All right, let's go in and see Ana.

Juan: Let's go in. (*Christopher and Juan enter the exam room to see Ana. The room has only two chairs inside. One of which Ana is seated in. The walls are painted white with nothing pasted on them*). At their arrival Ana smiles. Hola Ana, como esta? Muy Bien? (*Juan and Ana exchange kisses on both cheeks and Juan gives Enrique a handshake*) Enrique, this is our medical student Christopher, from the United States. He's here to learn, he's got a lot of information from his medical study. (*All the men are standing over Ana. Enrique stands right behind her. Christopher and Juan are standing to her right with a vacant seat right next to her*)

Christopher: I'm speaking with Doctor Garcia, (*Juan goes over to Ana to take her vitals*) and I'm looking at your chart Ana, and I understand you were diagnosed with AIDS, a little over a year ago. You were started on anti-retroviral medications

Shannon: Stop.

Joker: There's a stop. Go.

Shannon: I want to replace him (*Pointing to the medical student she walks to the stage to replace his position. Juan returns to his initial position in order to replay the scene with Shannon*). I guess just in general about translating. (*Seeming a little unsure*) So uh... (*Christopher hands her the notepad and file of the patient. Juan and Shannon both walk into the*

exam room to meet Ana and Enrique in there. Enrique is still standing behind Ana. At their entrance, they exchange the same greetings between Juan, Ana and Enrique)

Shannon: Hi, I'm Shannon. I'm the medical student from the United States.

Juan: Yeah, she's here to learn. You know we have some students coming in sometimes. *(To Shannon)* Why don't you have a seat, I think that will be better.

Shannon: *(Shannon takes the seat right beside Ana and is on the same eye level with the patient. Looking up at Juan, she asks)* Would you mind translating? I'll try to stop after I say everything.

Juan: Sure.

Shannon: *(Looking directly at Ana and smiling)* Hi Ana, it's nice to meet you *(Ana smiles back at her)*

Juan: *(Juan translates to Ana)* She says it's nice to meet you

Shannon: I learned a little bit from the doctor. Would you mind me speaking openly about what's going on? Is that okay with him in the room as well?
(Referring to Enrique. Juan translates)

Ana: *(Nodding her head in the affirmative).* Mm-hmm

Shannon: *(Speaking to the Joker)* Just making sure it's okay, just in general translating things. I don't remember the rest of what I was supposed to say

Joker: Perfect. How did that feel different, Ana? *(Shannon returns to her seat)*

Ana: I felt like I had a part in it. Because with Chris, I was looking up at all of them and they were telling me. She sat down and I almost had the urge to

touch her hair because for the first time I felt like there was a person who literally was interested in "me" as a person.

Joker: What do you all think?

Morgan: Once again, calmer.

Shannon: I tend to see nurses... from my mother who was a nurse... I don't know if it's just that, but I think nurses know a lot more than me, in these situations, because they spend the most time with the patients. I use them a lot when I'm here. I make sure and make friends with them, because I know, not just for this reason, but I know they're going to be the ones who tell me what happened at 2:00 in the morning, what really happened, not just what's on the chart.

Christopher: I think it's really important in this situation particularly in global health, to think about what the potential allies are back home. While you may not be able to directly interact with them, you can try to either encourage the patient to scout those allies or to find them indirectly and try to bring them in contact with the patient. Like for example, with my own global health experience, I can guess that probably in this situation, even potentially in a place like Baní or somewhere nearby, there are these days HIV support groups, or activity groups, or something along those lines. I think an important part of care in that case is finding out what those local resources may be for your patient. In either reaching out to that organization and saying, "Hey, I have this patient who's struggling and needs more social support in order to ensure that she's adherent to her medications." Or

pointing your patient in that direction saying, "Hey, there's this group that's discreet and may be able to help you if you're interested. I encourage you to talk to them." I think forcing yourself to think about the world outside of the exam room is always really important.

Mumini: In Burkina, I work on community health clubs. That is a concept where we help people to be more organized in rural communities to teach them the basic knowledge of public health on how to control diseases, how to prevent diseases, and our first program is in waterborne related diseases like Malaria, diarrhea, worms, et cetera. It's a WASH program (Water, Sanitation and Hygiene). So through this program, I mentor people in my community. Just before my 12-year old patient died she said to me "even if you won't be able to save me, please make sure thousands of children in Burkina learn that brushing their teeth is important". I did it. I make sure thousands of children in Burkina learned how to brush their teeth through my medical student organization, the Burkina Faso Medical Student Association that I created with friends. I organized a lot of outreach to talk to kids in primary schools, teaching the students and the teachers the importance of tooth hygiene and the impact of this on health. Change, no matter what it is, starts by our self at our level.

Christopher: I think that trying to figure out allies is probably the biggest lesson anyone starting to go into global health can learn. Allies are everything and like, big and small. The person who is going to teach you the small cultural queues that go a long distance, the person who can help translate for you.

The high-level doctor who can give you some cultural cache- some power to actually make change because you're associated with them, the person who has the money. These are all really the organizations in towns that might be able to help out. I think it's particularly, important in medicine in America to think about these things. A lot of the times it's somewhat built in. You have the social worker in the hospital and you have people who this is their responsibility. I think it's particularly important if you're going to be doing global health work that you take on some of that responsibility, and be thinking about what the opportunities, and resources and allies are beyond the clinic because that's going to be key to actually having any success in the exam room.

Shannon: One of my best friends, her family was from Ghana, and she's also going into medicine, and so we started talking about kind of what her family dealt with, with healthcare and kind of politically as well, in Ghana, so we decided we wanted to take a trip to Ghana to see how their healthcare is run there. She had an uncle who's a doctor in Ashanti province of Ghana. We stayed with him and shadowed in a local hospital right next to his house. We were mainly in the maternity ward and the surgery ward. I had an interesting encounter with a nurse there. She initially was pretty hostile when we got there, since my friend was from Ghana, but she was still looked at as an outsider, they called my friend Aberoni, I think that means, like, white man. They would always call her that, so she was kind of taken aback by that, too. Anyway, this nurse we were talking to, she was a little

bit upset, because she said, you know, "If I came to the United States, I would not be able to do this. We don't need the white hand coming in here and saving us. We do it how we do." We weren't really trying to implement anything. We were really just there to learn from them, and so it was an interesting conversation with her, just about what our role really is in foreign countries, and just coming in and being taught by these people that, you know, if they tried to come to America, they wouldn't be able to do the same thing. They wouldn't be allowed into a maternity ward. Then we talked to her a lot about it, and really told her, "Yes, and it's so amazing that you're doing this for us, and hopefully we can work together to try to figure out ways to make this a good experience for you, too, and hopefully, it can be a mutual relationship between us." Then we kind of started to become friends. The main thing she taught us after we kind of got through that part of it, she was really like, "Well, when you're here, you do, you don't learn".

John: I know that people in general have negative interactions like these. One time in the operating room between a surgeon and a tech, it was something along those lines where the surgeon didn't necessarily ... Even though the tech maybe had good advice about something that was going to happen or that the surgeon should have listened to and he didn't, it kind of bit him in the butt later on. He could have used that advice or help. I think it's just more like that type of interaction, just the cold, focused on your own thing, not looking at the person who's standing next to you, because you're too

worried or busy about yourself. That style of interaction where one person is trying to reach out and actively engage with one person, the other person doesn't.

Slide: Overwhelmed

The scene cuts to Christopher soliloquizing over the challenges he is facing in Santo Domingo. He is standing down stage center speaking to the audience.

Christopher: *(Pacing DSC)* Oh, what am I supposed to be doing here? I came down after my third year, thinking that I knew what I was doing. I worked with team six, *(Stops pacing, and now faces the audience squarely)* I have a decent idea about HIV, but I come here and they *(pointing behind him)* expect me to speak Spanish and understand all of this cultural stuff, and deal with this sketchy boyfriend guy that I don't know what's going on there *(Sits down on the chair slightly defeated, a slight pause)* Doctor Garcia seems really nice, but she never has time for me, and I don't know how to actually connect or ask her any questions because I don't want to be the imposing medical student. I'm just feeling super lost right now, I have no idea how I can be at all useful in this situation *(places head in hands)*. I just see a mess *(Throwing his hands up in the air with his eyes to the ceiling)*. This is way beyond anything that I think I'm prepared for. I mean *(Stands and starts pacing again)* I'm not a social worker in the US, much less in the Dominican Republic. If she's not taking her medications, *(Stops pacing)* I don't know how much I can really help her *(Looking through the patient file he walks DSR)* It seems like the issues are just

way beyond me. There's some drama in her hometown, there's some drama with this boyfriend. I have no idea what he's doing with her, and it just doesn't seem like I have... There's no one to help crack that. It really would help to know Spanish, first of all. I live in Texas, and I can order a taco at 10 PM, but I don't know that I can survive practicing medicine in the Dominican Republic. I feel really overwhelmed by that, and I don't know what the social situation is for her at all. I don't know if there are any resources here to help her out. It just... (*Sitting down defeated DSR*) again, I feel pretty useless.

John: There have been moments where I have been like that; very frazzled, excited, optimistic, jumping into a brand new experience, and then very quickly realizing that I was in over my head (*Looking thoughtful*). Yeah, in the first week of my third year where it was my first week in a hospital. I had been in the classroom the first years learning all this material, and then I go to the Military Medical Center, which is an army, air force hospital for my first four weeks of third year, which is your first year in the hospital in the clinics. I was kind of thrown into the fire pit of internal medicine wards. They treat their med students over there a lot differently than they treat the med students here at University Hospital. I think they have higher expectations. They kind of view you... This was my team. It might not be for every team, but I feel like it was a lot more academically driven at University Hospital than the VA was. At the other hospital it was more course work driven where we were viewed more as people who

could help out and you worked harder, and maybe a little bit less learning, which at the time I thought was great. I felt like I was really helping and actively participating. Then I realized, "Oh wait, I'm actually still here to learn. I'm still in school." There are points where I was overwhelmed that first week, because I had so much work to do. I had to learn on the go and that was overwhelming.

Morgan: I've been in this situation as a medical student, like Chris's role where you're like, "I literally don't know what I'm doing. I can't speak the language. I don't know if I'm really helping people. I feel like I'm in the way." I think in that situation maybe the first time I did it, I thought that the easiest thing to do or the best thing to do was just adapt really quickly, as quickly as you can to your environment, because it's super stressful. I don't remember specifically what I did, but I found something that I think I was good at or I found a way that I could be helpful and then I just did that. I tried to do that really, really well instead of focusing on what I couldn't do or couldn't accomplish. I find this scenario to be extremely relatable. I feel like everyone at some point has been in that position where you're like, "Oh my gosh! I'm so overloaded. I don't know what to do and I don't have any time. What do I do?" I remember when Dr. Garcia said she had 40 patients to see. I feel that was very relatable. I obviously have never been in the doctor's shoes, but I have been in that medical student's shoes of having that doctor saying the same response. It's like, "Oh my God no! I have like 40 patients that I need to see. Can we just get this

done?" So, I think because that's such a relatable experience and that's such a common experience, I looked at Dr. Garcia and I was like, "I totally identify with this." So, it's not so much that I found it humorous that she has 40 patients, obviously, because having 40 patients is not humorous, but I think it's her reaction with something that I've found not to be uncommon from other people that I've worked with

Sarah: This scene reminds me of my experience with the patient in Laredo. I just felt so overwhelmed... and I remember freaking out

Teresa: I remember feeling this way that Christopher felt. It was during my surgery rotation we had to work in the trauma bay. Everything there is chaotic. Someone comes in, you gotta be ready with your sheers and cut off people's clothes, and so many things happen at once. Someone's cutting off clothes. Another person's listening to their chest for breath sounds, checking their pulses, so there are like 10 people working on the same person and you just have to act quickly. Usually those shifts, the trauma based shifts, would be after a 14hour day shift that I already had. I had to get to work at 4:00 a.m., work through to 5:00 or 6:00 p.m., and then do an overnight shift. I felt so exhausted to the point where I was delirious. Sometimes the culture of surgery is that, it's like if you're doing something wrong, they ... I don't want to say yell at you, but they're very stern and you always feel like you're doing something wrong. Not doing something wrong, but just getting your wrist slapped. Especially since I was a third-year medical student, and this was near the very, very

beginning of the year, I just felt flustered. I was exhausted, just like Chris. It was like you don't have time to even sleep. It's like you're just working the entire time. I think that did contribute to some burn out even though that was the very beginning of my third year. It was just, eight straight weeks of that was exhausting.

Shannon: I think it is very striking to me when the medical student is trying to speak to the physician, besides, you know, everything that is going on with the patient, like actually, that was my life for all of third year. Even here, trying to interact with physicians who are incredibly busy, who have to see 40 patients a day, trying to do the best for the patient, but also, you want to know what's going on. Third year, you're thrown into this weird situation where you're a doctor, people call you doctor, and you're like, "A doctor? Please don't call me that." (*Laughs nervously*). It's kind of terrifying, so I definitely empathized with the medical student in that situation. I remember I had a similar experience in Guatemala. We were in an HIV clinic. It was part of the hospital. They only see HIV patients and they have to go through their psychological appointments, they have to get their prescriptions, they have to go through all these check boxes to get everything for free in this program, and so we had a young woman come in. I wasn't actually with them, but I kind of was with the group and heard about it afterwards. It was a woman that came in and, pretty much the exact same situation, that her boyfriend, I don't know what they, what she actually called him, but he came in with her and wouldn't leave them

alone. It was very much sort of the same situation. I don't believe she was pregnant, but she had uncontrolled HIV, and I think it was AIDS at that point. Afterwards, we kind of stepped back, and the doctor that was there was like, "Yes, that was her pimp," or that was, I don't know what other word they use there (*Looking thoughtful*) That, I'm like, "What do we even do in that situation? One, we're not from this country. We don't really know how the in's and out works of that. How do I approach that in the future?" Even in America, how do you approach these things? Especially a situation that a person can't get out of? Like that's the only option. It was kind of like a kind of a scary moment. You don't know really what to do.

Zoe: I identified with the medical student in the sense of showing up at a new place, you don't know anyone, you go in like you introduce yourself, you're trying to basically treat the patient. I mean, you want to treat the patient and be a good doctor.

CJ: Asides from portraying this role, I can certainly empathize with the feeling of being useless, or overwhelmed by the level of challenges that a patient has. On my Dominican Republic trip, there was a fairly similar patient. There was a woman in one of the villages that we visited who was a sex worker, and was HIV positive and was very fearful of stigmatization about that. We had to arrange for the gynecologist to be able to see her separately from where we were doing the rest of the clinic. In order to do a pelvic exam on her and discuss treatment options and get her medication where others couldn't see it. She only spoke- she's Haitian Creole- she

only spoke Creole. I couldn't actually communicate with her. I'm doing like, taking her vitals and whatnot. We had a Haitian gynecologist so he was able to speak to her. In that situation, I just felt very odd man out. Or like, how can I possibly relate to this person? Or really help her out very much right now? I think that that's a very familiar feeling or situation for anyone who does global health. Especially at this level of my training when I don't even feel like I have the medical knowledge, much less the cultural knowledge a lot of times. Which I think the point is, yeah, you're going to feel like that at this point in your career, you've got to be able to start working through it, and figuring out the ways that you're going to deal with that.

Mumini: This profession is an emotionally exhausting one. It has a lot of problems in it when you don't know how to detach yourself from your patients. So, sometimes that is the worst part of empathy because you are already overwhelmed by the problem of the patient. When your patient dies you spend three days of suffering et cetera (*slight pause*). We bear a lot of burden as healthcare professionals and sometimes the ethical part is the worst part that you don't know what to do.

Lights Fade.

ANA

Lights shine on Ana the patient and the students. Ana is seating on a chair, facing the students with her head bowed and her hands raised over her face as if protecting her from the view of others. Standing behind her is the personification of her emotions. This individual is also standing with her head bowed and her hands covering her face as though protecting herself from the view of others. As Ana walks DSR her personification struggles as though fighting with an imaginary adversary. The battle is ongoing as Ana speaks.

Mumini: Are you afraid of your boyfriend?

Ana: *(Looking around as though checking to be sure that she is alone, she puts her hands down, raises her head and begins to speak)* Terrified but...uh, he takes care of me *(smiling sadly)*

Shannon: Do you see any options for your different situation?

Ana: *(Looking puzzled)* For a different situation?

Shannon: To get out of your current situation, with your boyfriend and everything?

Ana: No option, no job. That's the best I can do now. *(A number of the students nodding their heads as she speaks)* I have a two-year-old, and now I'm expecting another *(pause)* so... *(As though re-assuring herself)* Enrique is my best option

Teresa: Do you feel bothered by the neighbors talking?

Ana: Yes, not only for me, but for my daughter and my mom. She goes to church a lot, so it's um... it's a big deal. I'd rather keep that personal and private.

Teresa: Do you think that affects your behavior?

Ana: You mean not wanting the neighbors to know?

Teresa: Yes. Do you have to change your behavior so that they don't find out?

Ana: Sort of, to some extent. Enrique comes at certain times of the night, when it's safe to go with him, or whoever the person, the customer is, at that point in time, so it's more private.

John: You have a two-year old?

Ana: Yes I do.

John: Is it a boy or a girl?

Ana: It's a girl.

John: What's her name?

Ana: Ana.

John: Ana? Beautiful name, just like her mother's. You want Ana to have a pretty good life, right?

Ana: Yes, I want her to have a good life, better than her mom, Ana. I think it's working because with Enrique, I can give Ana everything she wants.

John: What does she want, or what are you giving her?

Ana: Food, clothes, a roof over her head, somewhere she can sleep at night. I don't want her to go through what I am going through.

John: Do you think having her see or exposing what you're doing for a living to her, do you think that's a bad idea?

Ana: She doesn't know much. When I have to leave with Enrique, most times I take her to a friend's, or sometimes she stays with my mum.

Shannon: Are you scared of dying from AIDS?

Ana: *(Long pause, contemplating)* Sometimes I am, sometimes I'm not. It's hard. So, I try to take my medicine, and if it works, good. If it doesn't..., I'll try to make as much money as I can for Ana.

Male: Do you think you can get help finding a different job, or finding some way to make money through your mum...?

Ana: *(Cutting him off)* This is Santo Domingo, where do you want me to get the money from? *(Asking but not expecting a response)* This is what I know. *(Lights focus on Ana)* This is all I know *(speaking to the audience)*. This is the best I can do *(Walks DSR. As Ana walks DSR her personification struggles as though fighting with an imaginary adversary)* ... He is asking that question as though I have not thought through other options, as though I have not considered another way that I can try to make a living. How long have I struggled with this disease, with this reality *(The struggle intensifies with the personification)* What more lies ahead for me? *(A blank stare, as the personification falls in defeat to the ground, silently sobbing)* This is not what you plan for your life but this is the hand that I have been dealt. You cannot come *(Angrily)* with your way of thinking and suddenly expect that it can all be taken care of ...there are protocols, certain realities and challenges that I face daily as a single and expectant mother with HIV. Do I think I can get help finding a different job? He asks... And I ask in return, *(Speaking towards the students)* Where from? Who from? From a government too corrupt to care

for its citizens? Or a broken system in want of fixing? Who from? Again I ask. This is not the West where you have a voice and are heard. (*Walking back to her seat CSC*) This is Santo Domingo where you are lucky if you have three square meals a day. (*She sits*) No, (*shaking her head*) No magic wands will be waived over here. (*Both Ana and her personification bow their heads in unison using their hands to cover their faces from the audience*).

Slide: Complex Barriers

Teresa: Asking Ana about “how does her child feel with her in this type of work, in sex work?” And then she responds like, "Well, I'm going to have to feed my kid anyway. This is what I have to do to be financially stable." It just made me think about how there were so many complex barriers that were contributing to her not taking medications. On the surface, from the physician's point of view, we often simplify it to be like, "Oh, this patient's not taking their meds. Oh, they're a bad patient." In reality, it makes total sense from a public health type of view that that patient is doing everything she can to support her child. Yeah, so basically sacrificing, putting herself in danger to make sure her child gets every chance at a good life. I thought that was powerful.

Slide: Psychological Barrier

Mumini: Looking at Ana, I feel she is afraid of her boyfriend. And I even asked her "Are you afraid of your boyfriend?" And she said "Yes. A lot." Seeing that they can't have treatment at Baní, not because there's no treatment there,

but because of the psychological pressure, shows that there is not only a physical barrier to treatment, but there are some psychological barriers that sometimes are even more important than the physical barrier. From my background, I see people in my community crossing the sick bay and go to a traditional healer. This means that the problem is not with availability of the infrastructure, but there is a psychological barrier that we need to fix before they come to the sick bay. I know there are sometime economical barrier, but if you see this scenario with Ana, you see that it's not about money. They leave Baní to come to Santo Domingo. It takes money, time, and gas.

Zoe: I think Ana's character is more defeated than I was expecting, in the sense that I guess she didn't see any solutions to the problem in the situation she was in, and just kind of her sense that she had zero sense of self-advocacy in this situation. It was interesting to hear that coming out of her mouth. I've never experienced ... No I have, but- but it's always kind of surprising to hear it. I think it's also saddening. Maybe it's not surprising, but it's saddening to hear it, just like maybe that's their reality. Even if you can think of five million things, but they can't think of any, that doesn't really matter.

John: I think the patient Ana seems trapped. She is trapped in her situation. When you feel trapped, you can't get yourself out. You need help. I think that the people who can help you out the most are those who you feel the most comfortable with or those who have helped you in the past. I was

very struck by the boyfriend Enrique. I think that honestly because maybe things are so romanticized in society, we all kind of could predict how each character is, but Forum theatre kind of put it in your brain as someone who is real, so that actually makes it worse. In TV shows and movies and stories, that kind of boyfriend is a repeating theme. I guess maybe you just always think of it as more of the extreme issues. Then when you see it in this Forum theatre of an actual boyfriend, then it hits home and it's real. It's weird how something so recognizable and something I'm so previously... used to seeing now became almost a completely different experience, despite not changing at all, except for the fact that it's someone who is real and in front of me. I've talked to women who have been kind of involved in unhealthy relationships like that with their boyfriends in two different women's shelters. I couldn't resolve it but I cheered them up. I made them happy to be around me, because maybe they weren't used to being around people who could cheer them up. I tried to keep the mood light. I asked them how they're doing. If there was some sort of active project they were on, I could really probe into that. They tended to get more excited about that, whether it is something simple like just reading a book or maybe painting a painting or something along those lines as a distraction or maybe what I think is more of a positive reinforcement of the good things that are going on in your life. If I only have a few minutes to talk to them, I can't necessarily sit them down and convince them to leave their boyfriends who support them financially for

sexual favors or something along those lines. If I had more time maybe, I would.

Sarah: I wanted the boyfriend to leave. Deep down I was like, "Oh my gosh! I want the med student to tell the boyfriend, Hey, we need to speak with your girlfriend by herself for a little bit." Ugh! I thought that the boyfriend was being controlling. One of the things that really bothered me about- Okay, I had this issue in OB/GYN, too. A lot of women come in with their significant other, their father or their boyfriends. I felt like a lot of the information I was trying to get was not going to come from her mouth unless the guy left. (*Others nod their heads in agreement*)

Zoe: There have been I guess multiple times in my personal life that I had conversations with people that are in bad situations, and it's oftentimes younger people in high school, where they literally just see absolutely no idea. It's like, "You're smart, you can do this." I used to tutor a lot, and then it's like, "If you could learn this, then you could go to community college, you could do other things". That idea is convincing them that something else would be possible, than working as the checkout person at a grocery store is just... getting that through to them is just very hard, sometimes impossible, depending on the person's mental state. I had a couple kids that I used to tutor, and they were fairly far behind, they also didn't really have any role models. They were immigrants, their father didn't do anything, the mother was the one that was providing everything as a maid, and they had like no idea what they were going to do with their

life. There's a bunch of gang life around them, all that kind of stuff. It was like trying to convince this one guy, because he was a really good artist and I'm like, "Honestly, you could sell what you're making right now and you could make money, and if you go to camps or schools and you meet other people, they'll teach you how you can go about and make this out as a livelihood and you could do this for your life, because you really like doing it." It was just, he (*Long pause*) was more believing than his younger brother was, just like personality wise. His younger brother was really good at math, and trying to convince him that he could do really well at math and he could go do something with math, and he could finish high school before he was 18, or when he was 18, and all that kind of stuff. It was just, it was very... it wasn't kind of what they were being told elsewhere. I was kind of pushing them to think outside their box, and it was challenging. I think it's also like the personalities of the two, kind of what they were willing to accept and dream about.

Slide: Sociocultural Barrier

Mumini: I had a cousin who failed her exam and started having psychiatric troubles. Instead of taking her to the hospital, they said she was possessed. And they took her to the traditional healer that took her to many places, and since I know the cultural impact and cultural burden of this behavior, I couldn't just tell them "No, don't do that." Yeah, it doesn't work this way, and sometimes letting them go to the traditional healer, letting them see that it won't work because he will give potions, leaves, etcetera for

treatment. You tell them, "I'm not against your behavior or beliefs. I'm not an outsider, but from my background as a medical doctor, I know that the way she is, is not the way that someone who is possessed should behave." I try to explain to them "Maybe some people are possessed, but not this case. This case is surmenage -mental fatigue. It's because of stress, of studying, of failing her exam, etcetera, and she needs to be treated at a hospital. It did not succeed for my cousin. At the end of the day, they called me saying, "The healer said no after consultation, she's not possessed, and she needs to be treated at the hospital." Instead of blaming them, I said "Oh, I'm happy to hear that." And I took my cousin to the hospital and she got her treatment, and she got better.

Sarah: I am Mexican so I totally understand the whole gossipy neighbor thing. I was struck very much by the scene with the mother and gossipy neighbor because I see a lot of it in my own life, I guess, just because ... not that I'm an HIV patient working as a prostitute, but what I meant is that I grew up with my parents always wanting to tell the world, "My kid is doing great." They don't tell my neighbors, "Hey, she's doing poorly, she's unhealthy." They always want to put out the positive thing. It's always about conveying, "Oh, no, she's not skinny. She's doing great. She has a boyfriend now and he takes her to town." They try to find the positive in everything and convey that to the world, even if they know deep down everything is wrong. And then of course, the nosy neighbor being all

affectionate with the mom and the girl, deep down her motives are more like, "Oh my gosh, this drama."

Morgan: I think it's important to realize maybe the social context of the environment in the community that your patients exist in. I think that the gossiping neighbor character was essentially identifying that. I've definitely seen patients either in the emergency department or in ... first of all, in a broad context; I think that gossiping directly influences patient struggle to want to tell the truth to their physicians. I've also seen patients in the ED and especially in our GYN/TRIAGE ward where women will come in and they will have obvious signs of some sort of abuse. I feel like that a lot of those women, not a lot of them, but there was a couple times where we would suspect possible abuse or domestic violence or cases like that, and I think that women are really, really, really hesitant to, A, seek treatment, or to tell you the whole story because they're afraid. I think that that fear that comes from their relationship and then the social context which surrounds the relationship, which is usually some degree of low socioeconomic status. Maybe they can't have financial independence without their partner and stuff like that. They want to maintain that relationship even; because they know that it's harmful because they depend on it for their life more or less. I think that those kinds of situations obviously directly influence how patients relate to us in the broadest sense. That usually sometimes they have a hard time telling the whole story or even telling the truth.

Mumini: I witnessed children dying around me when I was a kid and sometimes it's from very poor families. I remember an epidemic of cholera that killed a lot of children in my village and my aunt even left with her two kids to come in my family in the city. She said sorcery is killing children in the village and she had to leave with her two kids. She said that sorcery is using the borehole. Like the wells, they put the disease in it and its killing children. That was false but it's her cultural perception.

Slide: Language Barrier

Sarah: I once had a situation come up in OB/GYN. As a student it's like "Oh my gosh, I don't" ... it was really hard. I had female patients that didn't speak English and they came from ... I think one of them was from Afghanistan, one was from Jordan. It's very hard to find a translator for Arabic and Farci. We were relying on the boyfriend, the dad or the husband as the translator. I don't know. You don't really know what's going on. You can't really ask ... We're supposed to ask with every patient, "Do you feel safe at home? Have you ever been abused, sexually, physically, verbally, emotionally?" You can't ask those questions when the significant other is right there.

Teresa: This one patient I had whenever I was in the medicine intensive care unit, she had everything. She had a history of several different cancers, had been treated in the hospital, she comes in very frequently. Everyone who's been on my team has worked with her. It's sad because she has all these health problems, but whenever you do sit down with her she's very cranky.

It's sad because she speaks Spanish and sometimes there's a language barrier so you can't really build as great of a rapport as you would with someone who does speak English. I think on top of that she was just very cranky all the time. I think in that way it was hard to treat her. To communicate with her we would use a translator phone which involves calling a number on your cell phone, and then having the person consent to the translation, having a patient consent. This is all over the phone, so it's like, you have to speak into the phone and then that person will speak to the patient, like this three-way communication. I can definitely see how that would be frustrating for the patient. Even if we wanted to go ... The language barrier also makes it hard even with the translation because I remember we'd explain something to her, and it's a lot of information. On a day-to-day basis, when someone is that sick, I'm sure things get lost in translation, or maybe she didn't understand it the first time. I remember, I don't know what we were talking about, but I remember going in the next day after we had explained something to her and she's like, "Well, why is this not happening right now?" I'm like, "Oh no. We talked about this." It's just difficult.

Shannon: I find that here, when most of the patients speak Spanish, I speak limited Spanish, and I always want to try to establish a relationship with my language, but I get very nervous about trying to translate with my language, because I don't want something to be lost. We use nurses here, and I worry a lot of times that things are getting lost or, you know, I'm not

really, they're not really getting what I'm trying to get at. They discourage using nurses, but sometimes that's, it's either me trying to translate or getting a nurse. I use translator phones and things like that if there is no nurse to translate. I think that... especially in a resource limited setting when you don't have the phones or the iPads that you have here, that makes me nervous about going to countries where I don't speak the language as well, well enough to translate.

Slide: Open Up

Shannon: I feel like sometimes that's the hardest part, to actually get a patient to open up. I feel like it really isn't going to happen unless someone comes and actually removes her hands. I think that is the whole purpose, to try to get Ana to open up, as the patient, to all the people around her. Even though they are there for her, if she is still in a ball at the end, there's not really any point to all the rest of it.

Shannon stands up and moves towards Ana CSC, looks thoughtful for a moment and then she raises Ana's head from its bowed position and drops her hands from covering her face to her palms facing upwards as though asking for help. Shannon walks DSR

Shannon: Patients here kind of nod and say "yeah, yeah I'll follow up. I'll do this, I'll do that," but some of them don't have the time to really get down to why they may not follow up, or, you know, if they don't have a car, they don't have a cell phone. "How am I going to call for my prescriptions? Or go get my prescriptions?" And things like that. One thing I started to do was to make sure I had a contact number for them when they left. I once had a

patient who had pretty bad fatty liver disease and she really didn't have any family. I think she had a lot of problems with her family. Her husband had left her and she was alone. I'm pretty sure she was also homeless. She didn't have a cellphone, and so we were like, "Well, we've got to figure out a way to follow up with her," because we set her up an appointment for the care link. We also set her up an appointment in the liver clinic, hepatology. We told her, "Here are all your appointments. How are we going to contact you?" She said, "Well, my sister has a cellphone. I guess you can call her. I don't always live with her, I'm not always with her," but like, maybe she can be. So I said, "Okay, well, if that's all we got." A week or so later, before she was supposed to go to her appointment, I called her to follow up. I called her sister, and she said, "Oh, she's not with me right now. Maybe in the next couple days I'll see her," and so of course I was like wow! I tried. I did all I could, and then her sister actually gave her the message, and she called back in. I wasn't there that day, but the resident that was on the team with me was able to talk to her and made sure she was going to go to the appointment, and she ended up going to the appointment. I saw she went to her care link appointment, and she also went to her liver appointment, which was kind of I was like. oh ok.

Finally! (*Laughing happily*) Yes. Finally! Yes, one patient. (*Walks back to Ana CSC, placing her hand on her shoulder*) You know, for every one there's probably you know ten others who don't, but it was one little victory, I guess.

Lights Fade.

POSTURE

Lights come on CSC. The actors are all on stage in different postures depicting the way they are feeling. They are frozen in these postures as described below.

Christopher: *(Standing slightly USR, facing the audience and backing everyone on stage)* I feel so useless.

Dr. Garcia: *(Looking at the phone with her other hand on her forehead standing to the right behind Ana).* So many patients to see, and this medical student, God

Juan: *(Stands facing the patient Ana with arms open as though pleading with her)* I wish there was more I could do to help.

Ana: *(She is seated with her face raised and her palms facing upwards as though asking for help)* Help me

Enrique: *(Standing with arms folded across his chest. He is slightly blocking Ana)* Let's get on with this

Ana's Mother: *(She is standing to the left of Enrique. She is facing her daughter with her arms outstretched)* I'm worried about her *(facing the gossip)* but the people...

Gossip: *(She has her hand over her mouth as though whispering to the audience a secret. She is lightly crouched as she speaks to the audience).* I think she has AIDS.

Joker: *(To the actors posing CSC)* Okay, stay there. *(To the spect-actors)* I want somebody from the audience to take one person, and make one change of

what that person is feeling. Make one change. It's okay to touch them.

What would you change about what they're feeling here?

Slide: Power of Love

John: *(Going over to the mother)* could I get the mom at the tail end of her emotion. Start off by saying "I'm worried about her." "I wanna do something about it." Can I have you come over to your daughter and kneel on one knee? *(Mother comes over to Ana and assumes the pose that is suggested by John)*. While holding her hand then you can say those lines to her.

Mother: *(Kneeling on one knee while holding Ana's hand)* I'm worried about her. Let me find out what's going on

John: My mom always tells me, "No one loves you like your mother," in the sense that no one loves you as much in the quantity or in the manner or the quality. I think that a mom will do everything in her power to fight for her children, regardless of the relationship, if it came to that particular situation. I thought if the mom approached her and said, "You can talk to me about it," who raised her, who breastfed her, and who saw her grow up into the woman she is that day, maybe she could break down that wall. Even just having one person to talk to can make the world of difference for someone. I thought the mom was the person who could be the catalyst to get the ball rolling. *(Returning to his seat)* I am closer to my mom of my parents. I think it's, once again, my dad did a lot of traveling both domestic and internationally for his job. My mom, she works during the

day, but in the evenings, she was home every single night. I used to grow up watching movies and TV with my mom a lot. I was also really sick as a kid and a teenager. My mom would stay in with me when I was sick. You never know the power of love.

Teresa: I don't think the mother did or said much in this situation. I mean she was concerned about her daughter but she was physically distant from her. However, this change by John is good, because in replaying the scene we changed her interaction with her daughter. Putting her hand on her daughter represented a form of support. My parents are first generation immigrants from China and Vietnam. My mum came here during the war and then my dad left China because he lived in poverty essentially and was trying to just improve his life circumstances. They came here and raised me. Asian culture, it's very ... You hear about the tiger mom? It was stressed that I do very well in school. That education is the most important thing. Without it then you'll be working a minimum wage job and not be able to survive. Nowadays I feel like you don't necessarily need to have all this education to make it. It's just an intergenerational thing that's very different. They're used to everything being very communal. Everything is about family. You listen to your elders because they're always superior to the child. Even now, I'm trying to figure out where to go for residency. I remember having this conversation with my uncle. He said, "You have an obligation to stay in Houston." He said that to me. It's not that I don't have guilt that I'm leaving my mom and then my

grandparents are getting older, but it just hurt that he was like, "this is what you need to do" instead of a more nurturing authority.

Morgan stands up and moves towards the gossip and changes her posture. She moves the gossiping neighbor to stand behind the mother. She places her hand on the shoulder of the mother and gets her to change her statement from "I think she has AIDS" to "I'm worried about her too, how can I help?". Morgan returns to her seat.

Slide: Part of The Solution

Gossip: *(Standing behind the kneeling mother, holding her shoulder).* I'm worried about her too, how can I help?

Morgan: I approached the gossiping neighbor, and basically told her to stop being a problem and stop gossiping and talking about stuff. It was making the situation worse. Be a part of the solution. I thought that that was an important thing to identify and address because stuff like that is obviously directly influencing the patient's care and it's directly influencing her ability to seek treatment. Does that make sense? I mean, right there, the fact that they didn't want to go to the clinic in Baní because there were gossiping neighbors that were talking about her possible affliction. That, obviously, is a very challenging thing to address and takes years and all this other business.

Sarah: I think this change is a lot better instead of just comment. It seemed earlier she was more motivated by gossiping. In this role she's more helpful. In a way, she's saying "I'm here to help, and I'm here to support you guys." I feel like posture makes a big difference in a situation. I grew

up in Texas. I think I have more privacy here. I think in Mexico ... I don't know, I always feel like there's a ... I'm trying to think of the right way. I guess within my family I feel like there's more gossip. My grandma recently passed away. I felt like the distant family was coming to the hospital to check on us. We had to be in the ICU waiting room at all times just in case something happened. I remember people that I didn't even recognize coming to us in their fancy church clothes and visiting us at the ICU. It was like, "Stop. Give me my space." I was miserable at the time. There were visitation times, so I'd go visit my grandma, come back. People would see the look on my face, and they'd be like, "Oh my gosh, what's wrong?" I'm like, "What do you think is wrong? My grandma is dying." That's what I wanted to say to them. I was very angry that they were there. They weren't close to my grandma; they were just there to pay their respects. I almost felt like they were a little too probing. At one point, even my dad and my aunts got mad because they were like, "Oh, they don't need to be here." I understand what it's like to have the nosy neighbors or distant family that you don't even know being there. I think my dad even said, "I wonder if they're just talking to each other and being like, 'Oh my gosh, let's go to the hospital to see the looks on their faces.'"

Teresa: People's behaviors change based on what's going on around them. All the sociocultural barriers really do affect individual health care. I am really interested in social determinants of health and I think the gossiping neighbor is a really good representation of stigma. I remember my

internship in Indonesia which was centered on HIV. Indonesia is a predominantly Muslim country, and a lot of the people lived in a predominantly Muslim, very conservative society. People were afraid, whenever they found that they had HIV, to tell their loved ones. A lot of cases only their partners knew and no one else in their immediate family knew because of things like spreading rumors. I think in Indonesian society, once you lose face or you know... community is so important there. Losing respect or being stigmatized from your community can have very profound effects on your daily living situation. One of the fathers I talked to, he was a former IV drug user and he had contracted HIV from that and his wife knew about it but his in-laws didn't. To this day he hasn't told them because he was saying that his in-laws are very, almost like fundamentalists. They are very strict about their religion and if they were to find out then it would completely destroy their relationship. It's a very real fear. Some people would even take their HIV medication labels off and rename it and say they were hepatitis C medications and so even though they are transferred through the same route, hepatitis C is less stigmatized and so people will do that.

Mumini: Sometimes when you show people that stigmatizing other people brings a negative impact, they can change. *(Mumini walks over to the stage and changes the posture of Enrique. He unfolds Enrique's arms and gets the mother to hold his arm. The posture changes to the mother holding*

Enrique with her free hand while her other hand still holds Ana.

Mumini returns to his seat).

Slide: Boyfriend Included

Mother: *(Kneeling and holding both Ana and Enrique. She looks at Enrique as though appealing to him)* Your girlfriend has a problem; I think she needs your help.

Mumini: I wanted the boyfriend included in the process because if you see the scenario you know that he is the one who can decide if the woman, the girl, Ana, will take the medicine or not. First of all, when Ana said, "please help me." He was the one who stood up as the obstacle. That's really something that teaches you something. Second, he was the one who brought food to the family, right? He was the one who took the woman to the hospital. He even doesn't know his status. I didn't know if he did the examination or not. Yes, I hear that yeah, he said he did it and he's negative, I'm not sure. Usually when it's up to sexually transmitted diseases, the treatment is better if it's the couple that is engaged in it. Once I had a patient who was sick and he didn't want me to tell his wife. The guy came with tuberculosis coupled to HIV, unfortunately. All his family thought he had tuberculosis but what is beneath, under it, they didn't know. Through different examination it came up that he has HIV. Normally it would be very good if he could say to his wife to go through the same procedure. Have the examination and if she's positive she could

take the medicine but I couldn't say it. I am not allowed to tell her. I think now it changed. If the guy refuses, you can.

Christopher: This is definitely a different perspective this year because other years, the focus has been on being very antagonistic towards the boyfriend character. In the past students generally just tried to get him out of the room or out of the situation. It's definitely a different perspective this year. If someone is saying, "well, why don't we try to bring him in, and make him more of an ally because obviously he's in this situation that's maybe not realistic that, we can actually get rid of him entirely. So maybe try to bring him in to support the patient a little bit more. That was completely left field from what we've had in the past.

Juan: I think it's interesting to think of an alternative approach, which would be to find out what his motivations are.

Dr. Taylor: To give a data point. The reality is that with many pimps, they don't use condoms with their people who they are pimping out. Ana and Enrique would consider themselves sort of safe within their relationship to not use condoms, because she's using condoms with everybody else.

Joker: A really interesting point for you to bring him in. I have to agree. I would have never considered that.

Mumini: Well, I'm happy to know this because usually, as you said, "some student would say, "Oh, please take him out." That's not the solution. The solution is rarely excluding people. It's including them.

Lights Fade.

PRACTICE

Slide: Achieving Balance

Lights come on with the students seated DSL

John: Achieving balance takes practice and skill. You have to become very efficient at your job, because once you're efficient at your job, then you will be able to work faster and more diligently but get the same amount of work done. I think also it's really easy to get lost in your work and only focus on the things that you have to do, but just remind yourself that you're there for the patient around you. A fun little thing that I did during third year was I had a Post-It note that was on ... I have this little foldable metal clipboard. On the back of the clipboard I had a Post-It note taped on it that just said, "Remember, it's fun." I'd always look at it. If I ever felt really tired or sad, then I would realize, oh wait, this is actually awesome what we're doing. I have a lot of friends who are in jobs, maybe stuck in cubicles where they're miserable for eight hours a day, whereas what we get to do is experience people saving lives. We help a little bit right now, but we're working to that point where we can save lives later on. Maybe if you just put a little note somewhere, a notepad just to tell them, "Hey, it's about the patient," I don't know. Maybe that's something I'll do.

Morgan: I spent some time, like four weeks, in Ethiopia then I did two weeks in India. Then in the summer I did a month in Bangladesh. I think that there is something about having to adapt very quickly to challenging situations. Usually, you have to find solutions to do that you wouldn't normally think

of. I think a lot of that you have to learn both patience and flexibility in order to do that. When we were in a clinic in Ethiopia and we were running the clinic, and I think the first day we did, it was incredibly hectic and chaotic and none of us really knew what we were doing, but I feel that we all identified roles that needed to be filled. I identified my role as the person that handed out the medications or measured out the medications. I think that finding a role that you can play or something that you can do and it doesn't have to be the whole big picture, but I think finding somewhere where you can help, I think, helps make that situation a lot less stressful. I think that, as a medical student going to travel abroad there's a lot of value in learning to be flexible and having to be open-minded and having to come up with solutions that are a little bit alternative. Because when structures are different and they're not what you're used to you have to figure out how to work within where you're working.

Christopher: I think anyone who does global health has to figure out how then they are going to navigate this different environment than where American medicine is going. How they're going to fit in to that with maybe some of the more empathetic values and patient partnership that we try to bring in, with still recognizing what the relationship is in the country we're going to practice and how you can be respectful of that.

Teresa: Those trauma-based shifts were very chaotic. I remember internalizing it. You know, not having enough sleep first of all and then whenever I finally had time to really process it, it was just a lot. Things got better. You

realize that not all of medicine is as crazy as surgery. You get more humane hours. You connect with the attendings. It's not like you're at the very bottom of the barrel. There are other scenarios where you work and you really do feel like you're part of the team. I think that makes a big difference when you're not only on a rotation to do the scut work or the work that no one really wants to do. It's when you're actually seeing patients, discussing it with the team, and it's more collaborative.

Zoe: I mean; I would just ask questions to try to figure out why they were doing what they were doing. Oftentimes, it was usually kind of gray areas that I experienced kind of the conflicts. You want to treat the patient and be a good doctor, but you also really need to impress your attending, and so you're trying to like balance the two, and like if they kind of conflict with each other, what you think should happen, and what do you do with that situation? We had a lady who had ruptured her membranes very early on, and previously this had happened to her several years prior, and she ended up losing the baby because she got infected, baby got sepsis, and delivered and they left it too long. They didn't deliver her soon enough, and so the baby got sepsis. She started having abdominal pain and tenderness, and I was of the belief that she needed to be delivered then, so that we delivered her as soon as anything changed, because that was prior what we had discussed as our plan, but there wasn't like, she didn't have a fever, all she had was this tenderness, but it wasn't horrible, and she could bear it. It was very ambiguous, but it's like I had worked with her, and this wasn't how

she was presenting previously, and I was like, "This has happened before, she lost her last child because of this. Let's deliver it now and give it the best chance it's got," but they didn't want to deliver the baby, because it was like 26 weeks. The doctor who was on, he hadn't worked with her before, but he didn't want to deliver this baby. To him, it was like, "I'm looking at this lady, she has no elevated white count. She has none of these things that would say we need to deliver her. She has this slight maybe increase in abdominal pain, but that's not that much to go off, and I don't think that one tiny little thing, with all the other things being negative, is enough to deliver her." He was explaining that to me and I was like, "I can understand that from your point of view, I just don't agree with you." I asked him a bunch of questions, and he was really great and he answered all of them for me, and I understood his position. At that time when we were talking, I was like, "Okay, I understand that, I can kind of get onboard with that," but then the next day I was like, I saw how it went, how everything happened after that, and then I was like, "I should've just like gone with..." I don't think I could have changed the outcome; I don't think I could have changed what he did (*looking distant*).

Shannon: I think, being in the physician position, definitely trying to balance your patients with all these extra pressures and trying to be one for the patient, but also having a ton of patients you're seeing at that moment, and delegating tasks to other people, it seems scary, but it kind of makes me sad that I'm not going to be able to sit with a patient for hours on end and

figure out what's actually going on, logistically. Hopefully, I'll somehow kind of balance the seeing 20 patients and also being able to get those relationships, but, so I think, hopefully, trying to balance all those things. I think now, I spend a lot of time in the rooms, and a lot of times, there's a time limit, especially when the physician needs to be in there, so sometimes I get cut off and the physician has to come in because she has three more patients to see, she or he. I think shortening up, asking questions, more important questions, sometimes. I think as I learn more about disease processes, I can kind of ask less general questions, and really ask, "Oh, okay, so you're showing this symptom? Okay, that sounds like this, so let's ask more questions about that way," and then, I think that will also free up more time to actually figure out the emotional aspect, the psychological aspects of things as well, especially in like HIV clinic, when you're telling people, you're not telling them they're going to die, but you're trying to kind of balance telling them that in kind of a gentle way, but also trying to manage their health.

Mumini: My challenge is to learn how to be efficient. How to continue being empathic without being attached to them [*his patients*] so that it hinders my mood, my behavior. So, I meditate. I read a lot. So, I learned by reading about it. One of the readings that helped me a lot is Buddhism readings because it teaches you how to detach yourself from your daily endeavoring problems.

Morgan: I remember saying calmer during the changes with the doctor and the medical student. That statement meant, A, exactly what it means. It's calmer, but also, it's less hectic. It's more organized. People are not operating with such frantic motions. When both Chris and Dr. Taylor played their respective parts, I know it wasn't acting. They were very much imitating the frantic, hecticness of seeing all of these patients, having too many things to do, of not knowing where you are, how you're contributing. They're basically externalizing all of this internalized anxiety and basically having to carry out their respective things and not really knowing how to get those things done successfully. I was rotating in the ICU. This was like a crazy, insane ICU and there were ... People were coding, basically meaning that their heart stopped and we had to get CPR to them and perform extraordinary measures to bring them back. Every day, every other day it was just ... It's the craziest ICU I've ever been in. I had two attendings. Actually, I had more than two attendings, but two of them were really, really, really calm in how they ran codes. The codes were so much more efficient. People were not freaking out. They were timing everything right. People were calm and efficient and doing what they needed to do. I think that the leader of the code, or the attending physician essentially set the tone for that by being calm and remaining calm. Then I had another attending who ran a code and she was just like, crazy and she was yelling at people and screaming at people to bring her things and there was like 40 people in the room and there was like five

doctors trying to run this code and she wanted to run the code more than anyone else. She was just screaming, screaming, screaming and everyone did not know what was going on. I contrasted these and I was like, "Hmm, which strategy works better?" So, that's why ... I think because of that experience, that's something that I want to carry with me through my patient practice.

Slide: Patient Treatment

Morgan: A basic for me is always to go in and treat someone like a human and ask them "What is... what's going on? Tell me your story". I feel like even if you only have five minutes, those five minutes are better spent asking someone, "Tell me what's going on." And then if you're really good then you can hone it in and use the rest of the five minutes to pick apart what you need to, but that takes a lot of time; which I don't have that experience yet. I think it's very important to be humble and have humility, especially in the context of your patients, in the context of your nurses, in context of your superiors and the people that you work with. I think in understanding that my patients are not beneath me because they don't have my education or my nurses are not beneath me because they don't have my education, but similarly, I am not beneath someone because I haven't had their experience. I think that in some way being able to modulate the fact that all people are really deserving of the same fair and equal treatment, I think is something that I took from a religious concept and still use it to

influence how I treat not just my patients but people in general, or at least I'd like to think that way.

Mumini: I find that listening is very important. If you don't listen they won't listen to you. How do I expect someone to listen to me, to see things from my perspective if I'm not humble enough to see things from his perspective? to listen to him, to understand why he is doing what he is doing. You can't assume that because you went to school you know everything. You can't assume that because you are a medical doctor that the way people are behaving centuries ago is just false. I used to tell the story of me and my friends. We went to a village to talk to people about hygiene, and my colleague started telling them that "you know, if you don't wash your hand before you prepare for your husband, it's being dirty. It's not good. The old lady told my colleague that "you are completely false." Yeah, because a dirty woman is a woman who has her period and cooks for her husband. It's not a woman who didn't wash her hand. So, the conception of hygiene is completely different from your perspective and you first need to understand this. And don't say it's false. Yes, you're right, but being dirty is also this, this, and this. Do you know what we call germs? No. Maybe she doesn't know. We need to teach her what germs mean. Even Western people spent a long, long, long time before the discovery of germs, so how do you expect my community to just discover germ from nothing? Without microscope, without any means of scientific and rigorous way of thinking? So, it takes time to make people change, and it's important to

learn from them. And how can you learn from people if you don't listen to them? So, that's why I emphasize on listening to people.

Sarah: One of the things that I think that I will carry into my practice is maybe instead of assuming, "Okay, this girl doesn't know what's going on. She probably doesn't care to take her meds," instead of making assumptions, always try to look back and think, "Oh, maybe there's a reason for that" and, "Oh, it should be convenient for Ana to go to the clinic in Baní. That shouldn't be a problem," when in reality it was a problem. Instead of leaving it at that, "Okay, I'll write your script. I need to go to this other patient," maybe be more respectful. They don't want to go back to Baní, that's fine. Even though I think it'd be more convenient of them. That's even without digging into the whole prostitution issue. I think another thing is to read between the lines with what's going on with my patients. You may not have time to have everyone in the hot seat and ask them all these questions.

Mumini: I once had a patient who had prostates. In French, we call it adenoma de la prostate. Not the cancer but the adenoma. It became bigger. He couldn't pee himself. He had to go through surgery. The problem was that the wound started getting infected. I had to sit with him and understand why the wound was still getting infected. It's just because he stopped taking his antibiotics, and whenever we come he'd show the empty thing like "Oh, I just finished it now." And we don't take the time to sit. We just say "Did

you take your medicine?" "Yes." We mark that, yeah, he took it. Instead of checking, really, that he did it or he didn't do it.

CJ: This training reminds me of what I don't want to do and what I don't want to be as a student and as a future doctor. I'm probably never going to be quite that rude or dismissive to a patient, but maybe I'll just get lazy sometimes and not be quite as on point, or up to par. I think doing something like this reminds me of, yes, it's important to make that commitment to every patient. You need to think about what's going on outside of the clinic for them. What they're bringing in to this and how important your interaction can be in their lives. Really ensure that every time you have that opportunity to make a connection, and make a difference, you really seize it fully. There are doctors who still think that scare tactics are an appropriate method. Actually, with experience and some experience in global health, I do think some of that patriarchal mentality or doctor patient relationship is still a little more of the norm in developing countries. I think there's still like more of a power dynamic distance between doctors and patients, an education difference, a socio-cultural difference. I think it's still a significant culture norm to be more authoritarian, and direct, and give instruction rather than partnership, which I don't like entirely condemn. I think that there's a cultural aspect of that in which patients expect that also. There's not an expectation of partnership, and then sometimes there's like, "Yes, you're the expert here. Tell me what I need to do."

Teresa: There's definitely this power dynamic between patient and doctor. As doctors, we think about this. There's this disparity where you're the person in charge, you have all this knowledge, and you're trying to explain something to a patient, and you want to make sure they understand, but sometimes patients will be like, "Oh yeah, I understand," but not actually understand. I don't know. There's this disparity between knowledge and education. I think it takes-to eliminate these disparities- time, patience to explain all the side effects and why they need to take it, their disease process. I think maybe using visual aids or teaching the patient and having the patient explain it back to them can help you be on more of an equal ground with your patient. I think that builds trust and I think that enhances health literacy, like really understanding what's going on at the moment. My dad actually passed away last August and I think that did bring us closer together. My parents don't speak English. Being the only medical person in the family, I felt like I had to go back to Houston and be the person that explains all the doctor medical knowledge to them. You know, deciding on whether he needed chemo or all this other stuff. I think that was a big transition in the relationship with my parents.

Zoe: The idea of awareness and listening to the patients is reinforced for me. In some ways, at least at this school, I feel like it's always good to be reminded of that, and I think in some ways having periodic reminders of that so that you can continue it in your practice is obviously really important, but especially for us, understanding the cultural differences and

talking to them and trying to figure out like, "Why do I want to do that?", especially with something that's as stigmatized as HIV. In the case of the patient with the ruptured membranes, we had spent a lot of time with this lady because we had been on service with her for like a week, and she had been there the entire time, and we had spent a long time talking to her and counseling her. She was a very anxious person, so we'd go and talk to her a lot, you know, to help calm her down, answer all the questions, and that's fine, but it was one of those things like, when she started acting differently, me and the other medical student who was also on service, we were both like, "We need to do this now," and no one agreed, but the next day she was delivered. It was a different doctor. I mean, there is no right answer and there is no way that you can know what would happen either way. Maybe delivering the day before would have given the baby another one day in the womb, so who knows?

John: I think something you don't learn in the classroom but they really try to teach you on the wards is just awareness. This training has made me realize that I need to be aware, keep my head on a swivel. Not like I need to look out for something crazy to hit me, but just more like if I need help, odds are there's someone who can help you who is right next to you. You don't want to miss something, like any small sign that something could be going wrong, like with the patient, with Ana. I think that the attending Dr. Garcia, who was very, very busy, was just convinced that Ana wasn't taking her medication because she was forgetting or just was

unknowledgeable or ignorant or just didn't want to. When in reality it was she was voluntarily withholding it because she was pregnant. I think the doctor made us realize that you will be really, really busy a lot in your life, but you just need to make sure that you stop every once in a while and look around and make sure everything is where it should be.

Teresa: When all the characters talked about how they were each feeling in the posture scene. They would say one phrase or word. I think that was a very succinct way to summarize all the complex feelings that we may be experiencing in the daily hospital setting, especially when it's super busy, which it definitely gets busy here. I can see myself having a very busy day and then thinking back to that scenario. It was a very real scenario. Especially since I'm going to be starting intern year, I'll be working with many different types of people in many types of roles, like the med students I'll have to be teaching them while also trying to learn the ropes on how to be a resident and I think that chaos... It just reminds me to put yourself in other people shoes because I want to be a good teacher to med students but I also want to be a good counselor to my patients and vice versa. So, if I find myself in a stressful situation, I'll just think back and remember that everyone is trying to get through the day. So just think about everyone's perspective.

Shannon: In the first interaction, like the first 20 seconds is how patients are going to, tell you things, how they feel, like right when you come into the room, and how you address them, and even like, using the right pronouns and

things like that for the males and with the females. I was kind of counseled by the doctors in Guatemala about using the word ... (*thinking out loud*) What is it?... It's like sir or ma'am, but it's a specific one for that area in Guatemala that they use. I got counseled in that, and then, right when I went in the room, I was like, "Hola," like blah, blah, blah. I can't think what the word is, and that's how I addressed them. I felt like the relationship was a little better going forward, even though I wasn't speaking Spanish full time, but at least I kind of made them feel comfortable when I walked in the room.

Mumini: Empathy is something I really care about and that's what led me to medicine. I witness many of my colleagues who really don't care about what their patient can feel. They just think medicine is giving medicine to people. Take two paracetamol and your headache will cease. No, it's not true. Even welcoming a patient can change a lot of things. Even by just sitting and listening to him, taking the history of the disease, you can make a huge difference.

Shannon: In treating my patient who had pretty bad fatty liver disease, some days I would go in there when I would have time and sit down with her. One day she said, "you know, my children got taken away from me, my husband got taken away from me". I was like "okay, well do you have like one place where you live, or," and she was like "well you know sometimes I go here" so it seemed like she was kind of going from place to place. I think we became a little bit more friends, at that point. At the beginning, it

was just kind of all business, but I think, as I started going there every single day, she was pretty talkative, so she would start telling me about her kids. I'd ask more questions you know, and she was also pretty depressed as well, so I knew that if I didn't address that, she would not be taking her medications afterwards, there's just no point for her. She didn't have her kids, she didn't have her husband. She would even tell me, you know, "I have nobody". It's like, "Oh, okay. Well, all right, this week, you're going to have me." (*Laughing*) I think we kind of developed a relationship. It wasn't, you know, after that, but it took a week or so. She was there for probably about two or three weeks. This is how I sort of figured out that she was homeless.

Mumini: During my clinical life, patients want to be taken care of by me. They want - Oh, how do I say it in good English? - They wanted me to treat them because we spend more time on talking about the history of the disease. Talking about the real history, it's not their private life, but I talk to them to understand where they live and the relationship they have with people from their family. Who is taking care of him at home? Who is in charge of paying for the medicine? Etcetera. It helps to even decide what medicine to give to him according to his financial situation. But sometimes people without empathy, without caring about this, they will just write down the prescription and hand it to him. You don't know if he will be able to pay or not. (*Looking to the audience as he asks*) So if you don't take the time to talk to them, how do you treat them?

Lights Fade.

EPILOGUE

Lights come on to students chatting indistinctly in the background (CSL), some are packing their bags to leave the auditorium. John is talking to CJ about what he did on stage. Some students exit through (CSL) and others through (USR) all the while discussing about their experience of the Forum theatre session. Occasionally, a student pops by to say their farewells to Dr. Taylor and Kat before they leave the stage.

Dr. Taylor: I think this was a successful session. Looking at the evaluations, eight out of nine agreed it was useful for their learning experience. I think they enjoyed the performance. They asked questions along the lines that I was hoping. I like that the notion of identifying their allies was present for them. They were able to put themselves in the position of Christopher. They thought of using the nurse as an ally, they also understood the need for the medical student not to upset the doctor.

Kat: I think this Forum theatre session was a success. I think the success was as a result of the participation. Forum theatre makes it easier for you to learn because you learn by doing and that is one way to learn. You step in and do something about what you always see being done a certain way. This gives you an opportunity to go in and change it. Do something different.

CJ: I would say the session was a success, because I think participants took away a more meaningful or direct sense of engagement with the issues explored than they would from a more passive or traditional method of teaching about challenges in Global Health work.

Dr. Taylor: I like the fact that Forum theatre makes the dilemmas we think about in the abstract concrete for them. No matter what, there are scenarios that we all run into when we're working in other countries that make us uncomfortable. We are hoping that in showing something real, hopefully when this happens to them, in whatever iteration it does, they will be less blindsided.

CJ: I think this year had a pretty good mix of students that were willing to get in the mix and try things. Then I think particularly I was pleased with both the additions from actually having Ana and the gossip neighbor in it as well. I think there was a wider view on the home situation for the patient, and some of the social issues that she's facing. I think in the past, there's been a little bit more of a restricted focus to the clinic setting, and not quite as much of the pulling back the curtain and seeing what's going on at home.

Kat: I think they need to count their lucky stars to be studying under these guys. *(Looking towards the medical students as they exit)*

Lights Fade.

V. FINDINGS

These medical students focused mainly on the lead characters in the play: the medical intern and the patient Ana. The medical intern is an important role for them as they are all about to go into their year of residency. The patient Ana is important because she represents a category of patients they may encounter when on a global health trip. Additionally, some of the participants had already had some global health experience, which influenced their understanding of the play.

As I read and re-read my data, I kept in mind Merritt's (2013) perspective that interactions, as facilitators and constituents of understanding, sense-making activities within group collaborations, are predefined by a joint goal or desired outcome and so are modulated by the dynamics of the interactions as well as in relation to the project. In this study, the group members are 4th year medical students preparing to become effective medical interns and eventually medical doctors in a low and middle-income country (LMIC). The actions and utterances of individual collaborators would "make no sense" without the presence of this mutual project (Merritt, 2013). Thus, through interaction in the Forum theatre training, the participants are involved in meaning-making that is central to their upcoming professional roles.

The key themes I identified from analyzing my data include the following:

- Mind, body, and emotion intertwine in meaning-making
 - Mind
 - Body
 - Emotion

- The familiar viewed as a new or different experience
- Culture as influencer
- Social anxiety in learner participation

I will address these themes in the following section.

Mind, Body, and Emotion Intertwine in Meaning-Making

In analyzing these data, I discovered that, the mind, body and emotion were all intertwined in the meaning- making process for the participants. The medical students would watch an action on stage, which would trigger an emotion within them. This emotion would connect them to a memory, which in most cases would lead to them coming up on stage to effect a change in the scene. The action carried out by the medical students reveal the rationalizing that occurred for the participant in that scene.

Mind. The human mind works by forming mental representations and applying cognitive processes to them (Mayer, 2003). Boyer and Wertsch (2009), view mental representations as interpretations of those physical stimuli that impinge on our sense organs in terms of particular concepts of objects around us. Memory to them requires an elaboration of information about the past, including traces of experience, within meaningful schemata. The meaningful schemata in this study are how to be an effective medical intern and medical doctor in a low and middle-income country (LMIC).

Forum theatre used for professional training opens the doors for trainees to elaborate on information about the past in relation to what they witness during the training. Paivio (1990) provides an example of how the retrieval process of memory works through telling how his son told him of an incident in which he saw a dog

excitedly harassing a little boy. The scene his son painted in his story triggered Paivio's memory of a similar event, one that occurred to him and his sisters when they were children. Paivio remembers this incident because he was involved in it as he restrained the dog. Several aspects of the incident are relevant to understanding the process of memory retrieval. First his son's recollection of the earlier incident was immediate and spontaneous. Second, the recollection was embedded in the memory of the more recent event that elicited the recall of the earlier one. Finally, the entire pattern of multiple recollections was itself cued by their conversation. This illustrates how the retrieval process of memory may occur.

The participants in my study go further beyond conversing about their memories, as Paivio describes, to drawing on their memories to get involved physically in the present moment to depict their individual meaning-making of the scenario presented. They take on the role of spect-actors. For instance, they yelled "stop" when an action on stage was not to their liking. They physically came on stage to make the change they felt would resolve the ongoing conflict in that scene. Sarah succinctly describes this, pointing out the importance of body to making new meaning:

I felt like body language is a huge component when you're doing some rotation abroad. I think this little Forum theatre, we didn't only adjust what the characters were saying, we got to move them to different postures. I feel like posture makes a big difference in a situation.

However, as earlier stated, the mind, body, and emotion were all intertwined in the learning process of these participants. One is not devoid of the other, rather all work hand in hand to inform the other and enable the learners to arrive at the meanings they

made. Actions carried out by the participants on stage were not without some form of behind the scenes contemplation. These actions in most cases depicted how they carried out their practice or how they intended to carry out their practice.

An example is when Sarah goes on stage to replace the attending, Dr. Garcia in “breaking bad news”. She changed Dr. Garcia’s statement from “Tell her, if she doesn't take her meds she's gonna die” to “She needs to understand that this number is really low. She has a 50% chance of dying in six months. Maybe you shouldn't tell her right off the bat”. When I asked Sarah why she made this change to the scene Sarah replied,

I guess my point with her is, I understand she's busy and she has to go see a bunch of other patients; however, you need to find out what's going on with this patient, why isn't she improving? Why isn't she taking her pills? I thought she should maybe narrow down the medical student's responsibilities to a task that's going to take 10-15 minutes, hopefully longer. Also, I don't think it's appropriate for the physician to put a medical student in charge of, say, a big diagnosis, a big, "You're going to die." That's something that I think you shouldn't ask a student to be doing in the first place. I understand sometimes we're thrown into telling a patient, "Hey, you might have diabetes," or things like that. I don't know how to describe it, but there's a line that gets crossed. I also think, "Okay, it's the attending physician's responsibility to tell the diagnosis, or at least give that big bad news; not the student's responsibility.

Sarah was not pleased with the way Dr. Garcia instructed the intern to tell the patient her diagnosis. Sarah found this inappropriate on the part of Dr. Garcia. The emotion she felt watching this scene triggered her memory of when she once had to break bad news to a

patient that she was diabetic. Placing herself in the shoes of the intern, Sarah has a mental representation of a similar situation of her own experience. Drawing on this strong emotion that accompanied it, she identifies with the intern when she says;

I had to tell someone they were diabetic, that wasn't fun. It's a devastating illness. The patient was scared that she might have it... It turned out her blood sugar was really really high. It was one of those things that at the time I was overwhelmed...I think at the time, back then I was freaking out like "oh my gosh, this is really high" I told her "okay your blood sugar is really high". I wasn't sure what else I was supposed to say at the time. I think looking back now I would've been like, "Okay I understand it's really high, but the good thing is we know now. You can go forward; we can actually help you get better.

In talking to me about this experience, Sarah draws on her intense emotions and earlier experience to inform her thinking on what possible action she might have taken in this scenario. We see here how her reasoning was informed by current and past events to determine her future action in a similar situation. The emotional discomfort from this past event weighed so heavily on her that she stepped up to the stage and replaced the attending physician. Not only did she carry out this action, but she also explained the reason behind her action. This gives us a deeper look into how her mind, body, and emotion intertwine in the process of meaning- making.

Another example of this intertwining of mind, body, and emotion is Morgan's reaction when Mumini replaces the medical student in talks with the nurse in "breaking bad news". Morgan interacts with this scene saying that she felt "It was calmer". Also, in the scene "Potential allies" Shannon replaces the medical student to consult with Ana the

patient. Morgan also responds in a similar way saying, “Once again, calmer”. When I later talked to Morgan about why she had said this twice in separate instances she drew on her mental representation of a past experience

I remember saying calmer during the changes with the doctor and the medical student. That statement meant, A, exactly what it means. It's calmer, but also, it's less hectic. It's more organized... I was rotating in the ICU. This was like a crazy, insane ICU and there were ... People were coding, basically meaning that their heart stopped and we had to get CPR to them and perform extraordinary measures to bring them back. Every day, every other day it was just ... It's the craziest ICU I've ever been in. I had two attendings. Actually, I had more than two attendings, but two of them were really, really, really calm in how they ran codes. The codes were so much more efficient. People were not freaking out. They were timing everything right. People were calm and efficient and doing what they needed to do. I think that the leader of the code, or the attending physician essentially set the tone for that by being calm and remaining calm. Then I had another attending who ran a code and she was just like, crazy and she was yelling at people and screaming at people to bring her things and there was like 40 people in the room and there was like five doctors trying to run this code and she wanted to run the code more than anyone else. She was just screaming, screaming, screaming and everyone did not know what was going on.

Here, she directly linked her mental representation to the emotion, and both mental representation and emotion played into how she interacted with this scene. In talking to me about it, Morgan verbalizes this emotion. Thus, in reflecting on this scene, Morgan

drew on her strong emotional memory to make meaning of the scene on stage; in other words, she brought her past learning in a similar situation to her interaction in this instance. When I spoke to her, she then made these links clearly and said,

I contrasted these and I was like, "Hmm, which strategy works better?" So, that's why ... I think because of that experience, that's something that I want to carry with me through my patient practice.

This linking or intertwining of emotions to mind and body evident in my participants' words echoes Tobin and Tisdell (2015); Merleau-Ponty (1945) and Gendlin (2004) in their perspectives on embodied learning as it regards embodied adult learning, the lived-body experience and the inhabiting of one's body through a felt sense of being in the world, respectively. However, what my participants describe goes further than just intertwining emotions with mind and body in that it draws on a strong emotional memory linked to a mental representation (Boyer & Wertsch 2009; Paivio 1990) which impacts their meaning-making processes.

For instance, in the scene "potential allies", Shannon took the place of the actor playing the medical student on stage and replaced the medical student/ actor's mannerisms and approach of disregarding the nurse to paying attention to the nurse. In her rendition of this scene, Shannon asked Juan, the nurse, to assist in translation while talking to the patient Ana. Shannon also sat on the vacant seat beside the patient so that they were on the same eye level when talking. When I asked Shannon why she did this, she responded saying,

I tend to see nurses - from my mother who was a nurse- I don't know if it's just that, but I think nurses know a lot more than me, in these situations, because they

spend the most time with the patients. I use them a lot when I'm here. I make sure and make friends with them because I know, not just for this reason, but I know they're going to be the ones who tell me what happened at 2:00 in the morning, what really happened, not just what's on the chart.

She expresses another emotion here, the love of a daughter for her mother and how this has influenced her meaning- making and actions. She continued,

My mom always told me, you know, "If you see that a patient vomited in front of you, you better start cleaning it up. You better not call the nurse in to come help you out." She kind of always instilled this high level of respect for not just nurses, but all the support staff in the hospital, because you can't get a lot of things done when you still clean yourself off from all the rest of it, so I guess that's why.

Thus, Shannon immediately identified Juan, the nurse, as a potential ally, not only because of her relationship with her own mother who was a nurse, but also because through her mother, she learned to trust nurses as knowing more about patients than the doctors or interns. The mental representation of her mother triggered her emotion of empathy which led to Shannon treating the nurse differently than the actor intern had. She turned to Juan to assist her in translating for Ana when consulting with her. Memory in this instance with Shannon intertwines her mind body and emotion to arrive at her meaning- making of the scenario.

We see another example of the mind, body, and emotion intertwining in meaning- making in "power of love". In altering this scene, John, went on stage to change the position of the mother so that she was close to her daughter. He had the mother hold her daughter's hand, rather than being spatially far away from her. John also changed what

the mother said from, “I’m worried about her... but the people” referring to the community members in Baní to “I’m worried about her. Let me find out what’s going on”. When asked why he made this change John said

My mom always tells me, "No one loves you like your mother," in the sense that no one loves you as much in the quantity or in the manner or the quality. I think that a mom will do everything in her power to fight for her children, regardless of the relationship, if it came to that particular situation.

In this statement, John expresses the expectation that there is an emotional connection between a mother and child. This expectation led him to physically change the posture of the mother as well as what she said in the scene. I asked John where this expectation regarding the mother-child relationship came from for him, and he told me,

I’m closer to my mom. My mom. I think it's, once again, my dad did a lot of traveling both domestic and internationally for his job. My mom, she works during the day, but in the evenings, she was home every single night. I used to grow up watching movies and TV with my mom a lot. I was also really sick as a kid and a teenager. My mom would stay in with me when I was sick.

This recollection of growing up as a sickly child influenced how he made meaning of this scene with Ana and her mother spatially far away that led him to move them closer. He explained,

I think the patient Ana seemed trapped. She was trapped in her situation. When you feel trapped, you can't get yourself out. You need help. I think that the people who can help you out the most are those who you feel the most comfortable with or those who have helped you in the past. I have to mention her mom has helped

Ana through problems in the past. Ana would feel the most comfortable, definitely more comfortable than with the med student or the doctor. Maybe the nurse could help out, but I'm just thinking out of the characters that were involved right there.

Central to how John made meaning of Ana's situation was the feeling of being trapped. This spurred him to want to look beyond the surface of what may have been preventing Ana from taking her medication. John's action and statement show that he expected the mother to provide the comfort that Ana needed in order to let her mother become aware of the fact that she was not taking her medication because she was afraid that it would harm her unborn child.

This scene triggered John to reflect on how he intends to practice medicine:

This Forum theatre made me realize that I need to be aware, keep my head on a swivel. Not like I need to look out for something crazy to hit me, but just more like if I need help, odds are there's someone who can help you who is right next to you. You don't want to miss something, like any small sign that something could be going wrong, like with the patient with Ana. I think that the doctor, the attending who was very, very busy. She was just convinced that Ana wasn't taking her medication, because she was forgetting or just was unknowledgeable or ignorant or just didn't want to. When in reality it was she was voluntarily withholding it because she was pregnant. I think the doctor, it made us realize that you will be really, really busy a lot in your life, but you just need to make sure that you stop every once in a while and look around and make sure everything is where it should be. To achieve this balance takes practice and skill. A fun little

thing that I did during third year was I had a Post-It note that was on ... I have this little foldable metal clipboard. On the back of the clipboard I had a Post-It note taped on it that just said, "Remember, it's fun." I'd always look at it.

John went on to specify how he intends to act as he copes with the emotions of being a doctor

If I ever felt really tired or sad, then I would realize, oh wait, this is actually awesome what we're doing. I have a lot of friends who are in jobs, maybe stuck in cubicles where they're miserable for eight hours a day, whereas what we get to do is experience people saving lives. We help a little bit right now, but we're working to that point where we can save lives later on. Maybe if you just put a little note somewhere, a notepad just to tell them, "Hey, it's about the patient," I don't know. Maybe that's something I'll do.

John narrates how the emotion of sadness triggers a mental comparison of his job to that of some of his friends "stuck in cubicles where they are miserable for hours". This rationalization leads John to appreciate his job as a medical doctor saving lives. He walks about attending to patients in their wards, and thereby not stuck in a cubicle. To cope with the emotion of sadness and the feeling of tiredness he arrives at the action of writing on a notepad that it is about the patient and not himself. The intertwining of the mind, body and emotion in this instance echoes the perspective of Freiler (2008), on embodiment as a sense of connectedness and interdependence through the essence of lived experiencing within one's complete humanness, both body and mind perceiving, interacting and engaging with the surrounding world. The lived experience of making his rounds and comparing his job to that of his friends provides connectedness and

interdependence which informs his engagement with the surrounding world. In interacting and engaging with the surrounding world of medicine with his mind, body and emotion, John arrives at an intended action plan.

In the scene “boyfriend included” Mumini changes the position of the boyfriend to have him included in Ana’s treatment. When I asked Mumini why he did this he said;

A few years ago, I had a similar experience. It was more than hard because it was ethical. It was the opposite. The man was sick and he didn’t want me to tell his wife. The guy came with tuberculosis coupled to HIV, unfortunately. All his family thought he had tuberculosis but what is beneath, they didn’t know.

Through different examination we came up that, yeah he has HIV. Normally it would be very good if he could say to his wife to go through the same procedure.

Have the examination and if she's positive she could take the medicine but I couldn't say it. I am not allowed to tell her. I think now it changed. If the guy refuses, you can.

The mental representation of this past incident informs the meaning- making of this scene for Mumini. This triggers Mumini to consider another way to handle the situation with Ana and Enrique. In this mental representation, the wife was not aware that the husband had HIV. However, in the play, Enrique is aware that Ana has HIV. Therefore, the ethical issue Mumini encountered in the past, when he says, “it was more than hard because it was ethical” is not present in this situation with Ana. In identifying the burden involved with handling such cases, Mumini goes up on stage to include Enrique in the treatment process for Ana. In explaining why he takes this action, Mumini says:

I think that when I see this scenario, the boyfriend is- I'm feeling- like part of the problem. Maybe the student, or the nurse and the student, should engage him in the problem. He needs to feel that his girlfriend's problem is his problem, too.

They need to be prepared, and fight... You need to know that we bear a lot of burden as health care professionals and sometime[s] the ethical part is the worst part that you don't know what to do.

The action of including the boyfriend is arrived at by an intertwining of his mental representation which leads to him evaluating the situation. In dealing with the burden attached to making pertinent decisions as it relates to patient treatment, Mumini arrives at the conclusion to include Enrique in the treatment process. The action of Mumini on stage is prompted by the intertwining of his mind through mental representations in combination with the emotional burden, as it relates to ethics, which in turn determine his action in the given situation.

Body. Bodies, according to Gillespie and Zittoun (2013), are the locus and medium of experience, but bodies are not floating mid-air. They move through socially structured experiences and in a likewise manner, human minds move through experiences shaped by complex cultural artifacts. Bodies possess basic and embodied memory and move between inter-related social positions and within institutional structures, like threaded needles. These bodies stitch together the domains of experience into an integrated, meaningful, and thus intersubjective whole.

Looking at my data through Gillespie and Zittoun's lens, the medical students participating in the Forum theatre training were in the social structure of medical school. They were 4th year medical students, who at the time of the training were awaiting their

placement positions for their residency. They possessed experience from working in medical settings both within and outside the United States, specifically low and middle-income countries (LMIC). This training afforded them the ability to combine these experiences to decipher their approach during their year of residency and eventually as doctors.

In the scene, “open up” Shannon removes Ana’s hands from her face and raises her head. When I asked her why she did that, she said

I felt bad for Ana. I feel like sometimes that's the hardest part, to actually get a patient to open up. I feel like it really isn't going to happen unless someone comes and actually removes her hands. I think that is the whole purpose, to try to get Ana to open up, as the patient, to all the people around her. Even though they are there for her, if she is still in a ball at the end, there's not really any point to all the rest of it.

For Shannon, “opening up” a patient is the hardest thing to do as a health care provider. She thought it was necessary to be physically involved in the situation to determine what specifically ails the patient and not leave them feeling helpless. This scene triggers a mental representation of a similar instance Shannon experienced that relates to “opening up” another patient,

Patients here kind of nod and say “yeah, yeah I’ll follow up. I’ll do this, I’ll do that,” but some of them don't have the time to really get down to why they may not follow up, or, you know, if they don't have a car, they don't have a cell phone. “How am I going to call for my prescriptions? Or go get my prescriptions?” And

things like that. It's actually one of the saddest things, especially here. One thing I started to do was to make sure I had a contact number for them when they left. At this point Shannon told me about what she is currently carrying out in her practice to try to ensure that she opens up the patient to accept treatment.

I once had a patient who had pretty bad fatty liver disease and she really didn't have any family. I think she had a lot of problems with her family. Her husband had left her and she was alone. I'm pretty sure she was also homeless. She didn't have a cellphone, and so we were like, "Well, we've got to figure out a way to follow up with her," because we set her up an appointment for the care link. We also set her up an appointment in the liver clinic, hepatology. We told her, "Here are all your appointments. How are we going to contact you?" She said, "Well, my sister has a cellphone. I guess you can call her. I don't always live with her, I'm not always with her," but like, maybe she can be. So, I said, "Okay, well, if that's all we got."

A week or so later, before she was supposed to go to her appointment, I called her to follow up. I called her sister, and she said, "Oh, she's not with me right now. Maybe in the next couple days I'll see her," and so of course I was like wow! I tried. I did all I could, and then her sister actually gave her the message, and she called back in. I wasn't there that day, but the resident that was on the team with me was able to talk to her and made sure she was going to go to the appointment, and she ended up going to the appointment. I saw she went to her care link appointment, and she also went to her liver appointment, which was kind of I was like oh, ok, Finally! (Laughing happily) Yes. Finally! Yes, one patient. You

know, for every one there's probably you know ten others who don't, but it was one little victory, I guess.

Shannon initially felt intense sadness for this patient as she did for Ana. However, Shannon then felt joy, victory, and accomplishment in treating this patient. This prompted Shannon to do what she did in the scene with Ana. This mental representation served a directive function in autobiographical memory; Williams and Conway (2009), view these mental representations as important to the interpretation of one's past self, current self and possible future self. Shannon's past self observed that there is usually no follow up on how patients get their treatment. Thus, she saw a need to be more involved in the care of the patient. Her current self, made a conscious effort to follow up with the patient by asking more questions and collecting contact information in order to reach out to them to ensure they keep their next appointment. Her future self intends to continue with this approach in her practice. The intertwining connection with the mind, body, and emotion led to Shannon "opening up" Ana.

Shannon in her encounter in this scene experiences a variety of emotions when she is dealing with her patient with bad fatty liver disease as she reveals through her statement, "Finally! Yes, one patient. You know, for every one there's probably you know ten others who don't, but it was one little victory, I guess." Shannon expresses her emotions of joy, victory, and accomplishment in treating this patient. This statement reveals that emotion is an essential part of the embodied learning process, which the data in this study speaks to, and as such is addressed in the next section.

Emotion. Emotions also play a role in human thought and action. Thagard (1996), explains that when we understand other people's emotions by imagining ourselves in their situation and experiencing an emotion that approximates what they feel. This kind of understanding is called empathy. As stated by Mumuni

Empathy is something I really care about and that's what led me to medicine. I witness many of my colleagues who really don't care about what their patient can feel. They just think medicine is giving medicine to people. Take two paracetamol [painkiller] and your headache will cease. No it's not true. Even welcoming a patient can change a lot of things. Even by just sitting and listening to him, taking the history of the disease, you can make a huge difference.

In a review written by Dayan (2015), he states that empathy demands not only that you recognize another's feelings, but also that you attend and respond to, become infused by and then act on, another person's feelings and needs. In this study, the 4th year medical students imagine themselves in the shoes of the medical intern in the Forum theatre training in order to understand the emotions he went through.

In the scene "overwhelmed" participants identified with the medical student's emotions during his internship in Santo Domingo. Christopher, the intern in the scene, soliloquized over the challenges he was facing. The medical students in the training made statements that revealed how they empathized with Christopher, the medical intern. This was mainly because most of them had been in quite similar situations as John explained:

There have been moments where I have been like that; very frazzled, excited, optimistic, jumping into a brand-new experience, and then very quickly realizing that I was in over my head (looking thoughtful). Yeah, in the first week of my

third year where it was my first week in a hospital. I had been in the classroom the first years learning all this material, and then I go to Army, Air Force hospital for my first four weeks of third year, which is your first year in the hospital in the clinics. I was kind of thrown into the fire pit of internal medicine wards...I felt like I was really helping and actively participating. Then I realized, "Oh wait, I'm actually still here to learn. I'm still in school." There are points where I was overwhelmed that first week, because I had so much work to do. I had to learn on the go and that was overwhelming

In empathizing with Christopher, John identified with the feeling of being overwhelmed as he recalled this instance. He discovered that he had to learn on the go. The emotional connection for John in this scene, makes him prepare to deal with such situations by learning on the go.

Teresa says:

I remember feeling this way that Christopher felt. It was during my surgery rotation we had to work in the trauma bay. Everything there is chaotic. Someone comes in, you gotta be ready with your sheers and cut off people's clothes, and so many things happen at once. Someone's cutting off clothes. Another person's listening to their chest for breath sounds, checking their pulses, so there are like 10 people working on the same person and you just have to act quickly. Usually those shifts, the trauma based shifts, would be after a 14-hour day shift that I already had. I had to get to work at 4:00 a.m., work through to 5:00 or 6:00 p.m., and then do an overnight shift. I felt so exhausted to the point where I was delirious... I just felt flustered. I was exhausted, just like Chris. It was like you

don't have time to even sleep. It's like you're just working the entire time. I think that did contribute to some burn out even though that was the very beginning of my third year. It was just, eight straight weeks of that was exhausting.

Those past eight weeks, represented a similar feeling of being overwhelmed for Teresa. This feeling of being overwhelmed generated an emotional connection for Teresa to this scene “overwhelmed.” Teresa truly identifies with Christopher in this scene and empathizes with him.

Shannon expresses her feeling of empathy when she said:

I think it is very striking to me when the medical student is trying to speak to the physician, besides, you know, everything that is going on with the patient, like actually, that was my life for all of third year. Even here, trying to interact with physicians who are incredibly busy, who have to see 40 patients a day, trying to do the best for the patient, but also, you want to know what's going on. Third year, you're thrown into this weird situation where you're a doctor, people call you doctor, and you're like, "A doctor? (Laughs nervously). Please don't call me that." It's kind of terrifying, so I definitely empathized with the medical student in that situation.

To be in a situation where certain responsibilities beyond one's expectation comes one's way is something Shannon can identify with. She empathized with Christopher in the scene “overwhelmed.” The feeling of empathy created an emotional connection for Shannon, which led to her belief and involvement with this scene through her mental representation.

Zoe expresses her empathy when she says:

I identified with the medical student in the sense of showing up at a new place, you don't know anyone, you go in like you introduce yourself, you're trying to basically treat the patient. I mean, you want to treat the patient and be a good doctor.

In empathizing with Christopher, the desire to be a good doctor in a new place and the pressure that comes along with that is not foreign to Zoe. The emotional connection for Zoe in this scene is due to the empathy she felt for Christopher in being overwhelmed. This feeling of empathy for Christopher is also identified in a comment by CJ when he explains,

I can certainly empathize with the feeling of being useless, or overwhelmed by the level of challenges that a patient has. On my Dominican Republic trip, there was a fairly similar patient. There was a woman in one of the villages that we visited who was a sex worker, and was HIV positive and was very fearful of stigmatization about that. We had to arrange for the gynecologist to be able to see her separately from where we were doing the rest of the clinic. She only spoke- she's Haitian Creole- she only spoke Creole. I couldn't actually communicate with her. I'm doing like, taking her vitals and whatnot. We had a Haitian gynecologist so he was able to speak to her. In that situation, I just felt very odd man out.

These quotes reveal how these medical students could easily place themselves in the shoes of Christopher the intern. They have a deeper understanding of how feeling so overwhelmed can take you over in the midst of trying to be an effective medical intern in a low and middle- income country (LMIC). Empathy generates the emotional connection

for the medical students to the performance as they make meaning of the scene where scene “overwhelmed” where Christopher soliloquized.

For Thagard (1996), the philosopher and cognitive scientist, the human body and brain have special mechanisms for generating conscious experience and using emotions to contribute appraisal, focusing and action. Emotions are not just incidental, annoying features of human thought, but have important cognitive functions concerned with appraisal, focus, and action. Through imagining themselves in the position of the medical intern in the Forum theatre training, the participants arrived at appraisals, focus and actions that revealed their meaning- making of the situation presented to them. As Morgan said:

I’ve been in this situation as a medical student, like Chris’s role where you’re like, “I literally don’t know what I’m doing. I can’t speak the language. I don’t know if I’m really helping people. I feel like I’m in the way.” I think in that situation maybe the first time I did it, I thought that the easiest thing to do or the best thing to do was just adapt really quickly, as quickly as you can to your environment, because it’s super stressful. I don’t remember specifically what I did, but I found something that I think I was good at or I found a way that I could be helpful and then I just did that. I tried to do that really, really well instead of focusing on what I couldn’t do or couldn’t accomplish. I find this scenario to be extremely relatable. I feel like everyone at some point has been in that position where you’re like, “Oh my gosh! I’m so overloaded. I don’t know what to do and I don’t have any time. What do I do?”

The emotion of being overwhelmed led to the appraisal of the situation to decipher what to do. This led to her focusing on that which could be done. This focus led to her action of doing “what she was good at” in the given situation.

In the scene “complex barriers” Teresa used the word “powerful” to describe the way she felt about Ana trying to do her utmost best to provide for her child. She said:

Asking Ana about how does her child feel with her in this type of work, in sex work?” And then she responding like, “Well, I’m going to have to feed my kid anyway. This is what I have to do to be financially stable.” It just made me think about how there were so many complex barriers that were contributing to her not taking medications. On the surface, from the physician’s point of view, we often simplify it to be like, “Oh, this patient’s not taking their meds. Oh, they’re a bad patient.” In reality, it makes total sense from a public health type of view that that patient is doing everything she can to support her child. Yeah, so basically sacrificing, putting herself in danger to make sure her child gets every chance at a good life. I thought that was powerful.

The verbal action of asking Ana this question, created an opportunity for Teresa to appraise the situation with Ana. This led to Teresa focusing on the reasons behind the actions of Ana, such that, rather than assume that she is a bad patient, she terms Ana’s choice as “powerful”. Teresa identified with this intense emotion, which triggered a mental representation as she said:

I think I did resonate very strongly with that. Since my parents are both immigrants. Yes, definitely. My parents are first generation immigrants from China and Vietnam. My mum came here during the war and then my dad left

China because he lived in poverty essentially and was trying to just improve his life circumstances. They came here and raised me.

A study by Damasio, et. al (2000) found a close anatomical and physiological connection between emotion and homeostasis and between emotion and mapping of the ongoing state of the organisms. This means that the authors found that emotions are connected to the physical body through the ability of emotions to affect the physical internal stability and the external state of the individual. These connections were evident when Mumini went up on stage to replace the medical student in “breaking bad news”. Mumini’s emotions impelled his actions. He says;

I felt that Christopher can play a key role because the doctor was giving up. I feel Forum theatre engages people emotionally. I felt the nurse is angry at the intern. He just felt the intern is not listening enough to him. So, I felt that it's important if I replace the intern and I listen to the nurse, I can change things in this scenario. So to make the change, I felt that in replacing the medical student, I will be in contact with Ana and then I can make a difference.

Empathy serves as an emotion, which is present for the medical students during this training. Through the presence of empathy, the medical students generated emotional connections to the scenes in the performance, which in turn impelled them into making certain changes to the scenes. Therefore, in embracing the emotion of empathy and acting as a result of its prompting, the medical students reveal how emotional connections are made and in turn contribute to meaning-making.

Summary

Intertwining mind, body and emotion in meaning- making specifies how the mind, body and emotions work hand in hand to contribute to the meaning- making of the participants. Although the mind, body and emotion have their separate functions, they are inadvertently linked in the meaning- making process. The emotional experience in humans, as viewed by Thagard (1996), is very closely tied in with physical changes that involve the whole body as well as the brain. This is evident as seen above.

However, highlighting some instances of this intertwining is revealed in the scene where Shannon opens up Ana, as discussed in Body. She arrives at this action as a result of the workings of her mind which are spurred on by her mental representations of her patient with bad fatty liver disease. Her experience with this patient informs her interaction with Ana in the scene “open up”. The intense emotion of sadness that Shannon feels for Ana triggers the mental representation of her patient with bad fatty liver disease. This emotion triggers the mental representation which leads to her rational contemplation of the scene to identify a possible action in light of the situation. Another instance of this emotional experience is seen in the section Mind where Sarah replaces Dr. Garcia in the scene “breaking bad news”. The emotional discomfort that Sarah experiences in this scene triggers her action to replace the medical doctor in the scene. This scene triggers a mental representation of a time when Sarah had to break the news to a patient that she was diabetic. She says, “I had to tell someone they were diabetic, that wasn't fun”. This feeling of sadness stayed with Sarah and was rehashed for her in looking at this scene where Christopher had to break the news to Ana that she was going to die if she did not take her medication.

In writing this section, it was difficult to delineate the mind, body, and emotion. This is because there is a connectedness and interdependence amongst them. This speaks strongly to how Freiler (2008) views embodiment as involving a sense of connectedness and interdependence through the essence of lived experiencing within one's complete humanness, both body and mind, in perceiving, interacting, and engaging with the surrounding world. Although separate in their makeup, the mind, body and emotion work together to lead the adult learner to meaning- making.

The Familiar Viewed as a New/Different Experience

The process of undergoing a training using theatre provides different perspectives of characters sometimes in ways that adult educators and learners may or may not expect. The theme reveals how the spect-actor views the character portrayed in the scene in relation to their meaning- making.

As a theatrical form of training, Forum Theatre possesses the qualities of a narrative. A narrative to Gillespie and Zittoun (2013), is not a single action or experience, nor is it simply a sequence of actions or events as seen from one person's point of view. Narratives have characters with differentiated interests, knowledge, values and emotions. To understand a narrative is to participate in this multiplicity of interacting experiences. For example, in this study, the Forum theatre presentation is seen by the 4th year medical students from the perspectives of the medical student, the patient -Ana, the nurse, the boyfriend, and the doctor, just to mention a few. In order for the participants to fully understand this narrative, they applied their minds, bodies and emotions to participating in the multiplicity of interacting experiences. This is evident in the study when John says,

I think that honestly because maybe things are so romanticized in society, we all kind of could have predicted how each character was, but the Forum theatre kind of put it in your brain as someone who was real, so that actually makes it worse. For me, I think it's the boyfriend that struck me the most. In TV shows and movies and stories, that kind of boyfriend is a repeating theme. I guess maybe you just always think of it as more of the extreme issues. Then when you see it in this Forum theatre of an actual boyfriend, then it hits home and it's real. It's weird how something so recognizable and something I'm so previously used to seeing now became almost a completely different experience, despite not changing at all, except for the fact that it's someone who is real and in front of me.

The presence of such a character before him on stage changes how John looked at Enrique from seeing him as a similar character on television, to this character right here right now on stage before him. The change in views and experience of this sort of character for John gives him a new experience on the effects of having such a character like Enrique in the life of someone like Ana.

Another example of the familiar as a new/different experience was in the scene “boyfriend included.” Here, Mumini changed the position of the boyfriend by unfolding his arms and getting the mother to hold his arm, such that the mother was holding the boyfriend with her free hand while her other hand still held Ana. Mumini also changed the words of the mother from “I’m worried about her, let me find out what’s going on” to “your girlfriend has a problem; I think she needs your help.” When I asked Mumini why he made this change he said in reply:

The boyfriend was the one who took the girl to the hospital. I wanted the boyfriend included in the process because if you see the scenario you know that he is the one who can decide if the woman, the girl, Ana, will take the medicine or not. First of all, when Ana said, "please help me." He was the one who stood up as the obstacle. That's really something that teaches you something. Second, he was the one who brought food to the family, right? He was the one who took the woman to the hospital. He even doesn't know his status. I didn't know if he did the examination or not. Yes, I hear that yeah, he said he did it and he's negative, I'm not sure. Usually when it's up to sexually transmitted diseases, the treatment is better if it's the couple that is engaged in it.

In recognizing the power dynamics between Ana and Enrique, Mumini identified the need to include him in the treatment process. Mumini addresses the scene by adjusting the perspectives of the mother and the boyfriend Enrique in relation to Ana. In changing the positioning of the boyfriend, such that the mother holds his hand and that of Ana's, Mumini presents these characters in such a way that speaks to the spect-actors on the untapped possibilities that have not yet been keyed into in the treatment process for Ana. The effect of this action by Mumini results in a new/ different experience for some participants as is evident in their statements, "I think it's interesting to think of an alternative approach, which would be to find out what his motivations are." With this statement, this participant is seeking to understand the motivations of the character Enrique rather than simply exclude him from Ana's treatment.

Sarah says,

Or ask him what's the last time he's been tested, since they're dating. Presumably find out she's pregnant, so the assumption is they are sexually active, and make sure that they're using condoms, and that they always use condoms, and "Oh, when was the last time you were tested? You need to get tested every this often. Let's do that today, since you're here.

With this statement, Sarah begins to realize the futility in treating Ana if her boyfriend may be a potential deterrent to Ana's treatment and even to his own health.

In the case of CJ, he says:

This is definitely a different perspective this year because other years, the focus has been on being very antagonistic towards the boyfriend character. In the past students generally just tried to get him out of the room or out of the situation. It's definitely a different perspective this year. If someone is saying, "well, why don't we try to bring him in, and make him more of an ally because obviously he's in this situation that's maybe not realistic that, we can actually get rid of him entirely. So maybe try to bring him in to support the patient a little bit more. That was completely left field from what we've had in the past.

This statement from CJ narrates how "left field" it is for him to include the boyfriend in the treatment process. Most past experiences with this scene had spect-actors wanting the boyfriend to leave the room, thereby providing one solution to the boyfriend issue-exclude him. The same was the case in this training session, only until Mumini brought to his attention the need to include the boyfriend in the treatment process for Ana.

Kat, in her statement explains that she would never have thought to do this had Mumini not made the change. She says;

“It’s a really interesting point for you to bring him in. I have to agree. I would have never considered that”.

These responses reveal how the action of Mumini in including the boyfriend, influences the perspectives of some participants to the point that they are shifting from their initial approach to exclude Enrique. They begin to suggest ways to include Enrique in Ana’s treatment process. This action by these participants illustrates how they arrive at a different approach towards Enrique. These statements evidence how the training led to participants’ experience of the familiar (Enrique) to one that is new/different. They view Enrique as a possible ally in their bid to treat Ana.

Jarvis and Gouthro (2015), conclude that arts-based education facilitates the capacity to accept and identify differing interpretations of reality which is central to successful professional practice given the increase in diversity in workplaces. In the case with John, Enrique does not feel like some distant faraway romanticized character on television. Theatre brings the character of Enrique before John such that he views him as an actual person in an actual real-life situation. This changes his view of the idea of Enrique to one of reality because this form of training puts a face to the name and physically presents the individual before him. In using dance as a way knowing, Snowber (2013), views movement and dance as a means to knowledge, and grapple more deeply with the complexity of ways students and teachers can critically think; sift, perceive and come to a fresh understanding of the subject being studied and make sense of the world. As an arts-based training, Forum theatre in this study gives John the opportunity to come

to a fresh understanding of the character Enrique. This also provides an opportunity for Mumini to present Enrique in such a way that other participants grapple more deeply to critically think, sift, perceive and arrive at a different understanding of Enrique.

Summary

In explaining how the familiar is viewed as a new/ different experience, I emphasize the contributions of art-based education to professional development training. In this form of training, participants had the opportunity to explore different approaches than they would have applied in similar situations. One of the many appeals of dramatic performance for Kontos and Naglie (2006), is the fostering of critical awareness, and engaging audiences to envision new possibilities. As a result, this dramatic performance leads to a raised critical awareness of the character Enrique for John, and the envisioning of the new possibilities to be achieved by including Enrique in Ana's treatment rather than excluding him.

Culture as Influencer

Culture as a theme in this study looks into the influence of the way of life of the medical students in their doctor-patient relationship. It also speaks to how these medical students borrow from their own cultural knowledge to make a positive impact in patient treatment. As a result, culture provides a certain amount of influence in their practice as medical interns and future doctors. Culture typically refers to the shared values, attitudes, beliefs, behaviors, and language use within a social group. These cultural values, beliefs and practices are at the core of group life and identity and are powerful factors shaping or influencing individual attitudes, beliefs, and behaviors (Guy, 1999). Culture is both a "here and now" dynamic phenomenon and a coercive background structure that

influences us in multiple ways (Schein, 2010). Thus, learning cannot be considered content-free or context-free, for it is always filtered through one's culture and cultural identity (Alfred, 2002). The Vygotskian theories of learning and development emphasize that learning occurs within a social world (1978). Social constructionism proposes that meanings are constructed by human beings as they engage with the world they are interpreting (Crotty, 2007). All reality, as meaningful reality is socially constructed. We import meanings to objects from our culture. As a theme in this study, this is particularly salient in that the medical student trainees are learning to interact more effectively as professionals in cultures different from their own. For instance, when asked why she asked the nurse to help in translation, Shannon responds,

I think, mostly about translating, because it's, I don't know if it was supposed to be that way, but they would just speak English right away... I think it just kind of bothered me about how the med student kind of came in. I mean, like the first interaction, like the first 20 seconds is how patients are going to, like, you know, tell you things, how they feel, like right when you come into the room, and how you address them, using the right pronouns and things like that for the males and with the females.

In acknowledging the need for translation in communicating with Ana, Shannon drew on her desire to connect with the patient. She identified a need to communicate effectively with Ana. Shannon felt discomfort at the way the intern spoke to Ana in English immediately when he came into the consulting room. This triggered a mental representation of a past experience for Shannon.

Well, I know I was kind of counseled in Guatemala about using the word ... What is it? It's like sir or ma'am, but it's a specific one for that in Guatemala that they use. I got counseled in that, and then, right when I went in the room, I was like, "Hola," like blah, blah, blah. I think what the word is, and that's how I addressed them. I felt like the relationship was a little bit better going forward, even though I wasn't speaking Spanish at that time, but at least I kind of made them feel comfortable when I walked in the room.

In the scene “sociocultural barriers”, Mumini talked about the sociocultural barriers to patient treatment for Ana, Mumini says

This scenario [with Ana] shows that there is not only a physical barrier to treatment, but there are some psychological barriers that sometimes are even more important than the physical barrier. I saw people in my community cross the sick bay and go to a traditional healer that means that the problem is not with availability of infrastructure... if you see this scenario you see it's not about money. They leave Baní to come to the place. It takes money, time, gas, but they accept to come. So that's why, and I felt concerned. I felt sometimes bad, or happy, or angry about some behaviors. So its engaged me, and made me reflect on my own way of behaving on how I can change things in my life, my daily activities.

Mumini drew on the intense emotions he experienced in watching this scenario, which triggered a mental representation of a similar experience in his past. This linked his past experience of bridging the different values and beliefs for people from different cultural backgrounds. He says,

I had a cousin who failed her exam and started having psychiatric troubles. Instead of taking her to the hospital, they said she was possessed. And they took her to the traditional healer that took her to many places, and since I know the cultural impact and cultural burden of this behavior, I couldn't just tell them "No, don't do that." Yeah, it doesn't work this way, and sometimes letting them go to the traditional healer, letting them see that it won't work because he will give potions, leaves, etcetera for treatment. You tell them, "I'm not against your behavior or beliefs. I'm not an outsider, but from my background as a medical doctor, I know that the way she is, is not the way that someone who is possessed should behave." I try to explain to them "Maybe some people are possessed, but not this case..." At the end of the day, they called me saying, "The healer said no after consultation, she's not possessed, and she needs to be treated at the hospital." Instead of blaming them, I said "Oh, I'm happy to hear that." And I took my cousin to the hospital and she got her treatment, and she got better.

Mumini's understanding of his relatives taking his cousin to a traditional healer exemplifies Trice and Beyer's (1993) inclusion of emotion as one of the six characteristics that shape the essence of culture. Since cultures help manage anxieties, they are infused with emotion as well as rational thought. People's allegiance to their beliefs, values, and cultural practices develop primarily from their emotional needs. As a consequence, members of a culture seldom question the core beliefs and values inherent in that culture. By not questioning their decision to take his cousin to the traditional healer, Mumini showed how culture manages anxiety. In addition, this helped him

rationalize the situation with Ana and led to his conclusion that there was more than just a physical barrier preventing her from coming to get her medication as often as she should. Mumini exhibits a similar cultural understanding in a situation with his aunty when he makes this statement,

I witnessed children dying around me when I was a kid and sometimes it's from very poor families. I remember an epidemic of cholera that killed a lot of children in my village and my aunt even left with her two kids to come in my family in the city. She said sorcery is killing children in the village and she had to leave with her two kids. She said that sorcery is using the borehole. Like the wells, they put the disease in it and its killing children. That was false but it's her cultural perception.

Rather than question his aunt's conclusion and belief, Mumini accepted them. In doing so, he helped his aunty in managing her own anxiety in this sudden death of children from cholera.

Another instance where we see culture contribute to meaning- making is with Sarah in her reaction to the action by Morgan in the scene "part of the solution". Morgan adjusted the position of the gossiping neighbor to one of genuine care and concern for Ana and her mother. Sarah said;

I am Mexican so I totally understand the whole gossipy neighbor thing. I was struck very much by the scene with the mother and gossipy neighbor because I see a lot of it in my own life, I guess, just because ... not that I'm an HIV patient working as a prostitute, but what I meant is that I grew up with my parents always wanting to tell the world, "My kid is doing great." They don't tell my neighbors,

"Hey, she's doing poorly, she's unhealthy." They always want to put out the positive thing"

Following on this understanding, she shared a mental representation that spoke directly to her meaning- making from the scene

My grandma recently passed away. I felt like the distant family was coming to the hospital to check on us. We had to be in the ICU waiting room at all times just in case something happened. I remember people that I didn't even recognize coming to us in their fancy church clothes and visiting us at the ICU. It was like, "Stop. Give me my space." I was miserable at the time... I was very angry that they were there. They weren't close to my grandma; they were just there to pay their respects. I almost felt like they were a little too probing. At one point even my dad and my aunts got mad because they were like, "Oh, they don't need to be here."... I understand what it's like to have the nosy neighbors or distant family that you don't even know being there.

Sarah also pointed to the importance of language and culture in patient treatment when she said:

I once had a situation come up in OB/GYN. As a student it's like "Oh my gosh, I don't" ... it was really hard. I had female patients that didn't speak English and they came from ... I think one of them was from Afghanistan, one was from Jordan. It's very hard to find a translator for Arabic and Farci. We were relying on the boyfriend, the dad or the husband as the translator. I don't know. You don't really know what's going on. You can't really ask ... We're supposed to ask with every patient, "Do you feel safe at home? Have you ever been abused, sexually,

physically, verbally, emotionally?" You can't ask those questions when the significant other is right there.

In explaining her reaction to the “sociocultural barrier” scene, Morgan shared her prior GYN/Triage experience. She told how this ward revealed to her how certain sociocultural factors can serve as barriers to patient treatment.

I think it's important to realize maybe the social context of the environment in the community that your patients exist in. I think that the gossiping neighbor character was essentially identifying that. I've definitely seen patients either in the emergency department or in ... first of all, in a broad context; I think that gossiping directly influences patients' struggle to want to tell the truth to their physicians. I've also seen patients in the ED and especially in our GYN/TRIAGE ward where women will come in and they will have obvious signs of some sort of abuse. I feel like that a lot of those women, not a lot of them, but there were a couple times where we would suspect possible abuse or domestic violence or cases like that, and I think that women are really, really, really hesitant to, A, seek treatment, or to tell you the whole story because they're afraid. I think that that fear that comes from their relationship and then the social context which surrounds the relationship, which is usually some degree of low socioeconomic status. Maybe they can't have financial independence without their partner and stuff like that. They want to maintain that relationship even because they know that it's harmful because they depend on it for their life more or less. I think that those kinds of situations obviously directly influence how patients relate to us in

the broadest sense. That usually sometimes they have a hard time telling the whole story or even telling the truth.

The feeling of empathy for these women is a palpable emotion that Morgan felt in these situations. This emotion triggered a mental representation of a case she once had.

I did have a case one time. I guess when I was in my first year of medical school.

This was before they built the new tower and the emergency room was crowded and the trauma bay was in there. They brought in two children. We were

suspecting possible child abuse because the story that the mother and the

boyfriend told us really didn't add up to the timeline of their wounds and the kind of wounds that they had and stuff like that. I remember asking, "What do you do

in this situation?" My resident at the time was, "If you suspect that there's abuse

you need to get CPS involved in the case," which we eventually did. The little boy

that was injured at the time, I think eventually died because he had a very severe

brain injury (pause) I think that was one that stuck with me for a really long time.

The pause in her speech suggests that her deep emotional involvement in this instance had a huge impact on Morgan. This emotion motivated Morgan into action in the “part of the solution” scene. In this scene, Morgan changed the position of the gossip, from snickering at Ana and the mother to holding the mothers arm and asking, “I’m worried about her too, how can I help?”

This is a change from her initial statement, “I think she has AIDS”. In stepping up on the stage to make these changes, Morgan revealed how her meaning- making process regarding sociocultural factors could have a negative impact on patient treatment. The

action of addressing the gossipy neighbor was an issue that weighed heavily on Morgan having seen what such actions can result in.

I approached the gossiping neighbor, and basically told her to stop being a problem and stop gossiping and talking about stuff. It was making the situation worse. Be a part of the solution. I thought that that was an important thing to identify and address because stuff like that is obviously directly influencing the patient's care and it's directly influencing her ability to seek treatment. Does that make sense? I mean, right there, the fact that they didn't want to go to the clinic in Baní because there were gossiping neighbors that were talking about her possible affliction.

Summary

Culture is evident in the data in light of tradition, language, and society. This theme reveals the extent of influence that culture has in the doctor-patient relationship, in the practice of the medical students as they embark on their year of residency and also how sociocultural factors may sometimes serve as deterrents to effective patient treatment. This theme also shines a light on the need to train employees to become more culturally equipped in our culturally diverse world. As Sarah nicely puts it:

“The US is a country based on immigrants, and every day we're getting new immigrants from around the world. I would hate to be the doctor that misses something”

Social Anxiety in Learner Participation

Social anxiety is a theme that was evident in this study. It pointed out how different learners may approach their challenge with social anxiety. This theme also gives

a heads-up to adult educators who may intend adopting the use of certain performance based approaches to training.

McNiff (2014) observes that when working with people in the area of creative expression, a common fear of appearing foolish or strange arises, and feelings even approach terror when people are offered the opportunity to express themselves in new ways with their bodily, vocal, poetic, or visual expressions. For the medical student trainees, social anxiety may have been a deterrent to some participants to go on stage. However, although some participants did not physically go on stage, they reveal their meaning- making process through speech, a form of action. Neither Teresa nor Zoe went up on the stage to make any changes in the scenes, but their meaning- making was evident in the data. For example, Teresa said:

I just get social anxiety. I don't like being in front of a big crowd of people. Yeah. I think for me personally it would help get me in front of an audience and work on the social anxiety I have. Yeah, you kept saying that I didn't go in front of the audience. I thought about that a lot that day actually because I'm just very aware of that. I know it's something that I've always wanted to change about myself.

Teresa was willing to participate in training like Forum theatre in the future because she thought it would benefit her in addressing her social anxiety.

Zoe had a similar perspective:

Like literally, for those of us who don't like to perform, like that is something that we don't want to do and we're going to avoid doing that at all costs, and you introduce the idea that we might have to do that earlier than like, "We're going to throw you into this idea now." You're like, "Uh, please don't make me do that," is

like my gut reaction. Knowing that I have to do that ahead of time to kind of like, how it would work for those of us who ... Because I know I'm not the only one who has that same kind of gut reaction like, "Please don't put me up onstage to act."

Shannon expressed a like feeling:

I was a little nervous about participating in it. It made, it like, because I do like to act, things like that, but improv is something that makes me a little nervous, especially, I get, my heart rate jumps up whenever I have to even say words in front of people, but then when I'm in it, I'm kind of like, "Oh, yeah, I'm excited about this. I'm going to do it," but then afterwards, I'm like, "Oh my God, my heart's racing so fast." I was a little nervous when I first started, honestly.

Although Teresa and Zoe did not come up on stage during this training, they said they would go up on stage next time if given that type of training, and also if the length of this training had been extended. In the end, Shannon overcame her nervousness and approached the stage to reveal how she saw one of the scenes.

Chapter Summary

In this chapter, I explain how Forum theatre draws on the mind, body and emotions of adult learners to contribute to their meaning- making. This Forum theatre performance provides a dialogic relationship between the stage and audience (spect-actors) Kontos and Naglie (2006), which facilitates the meaning- making process. These findings support Eisner's (1998) perspective on the ability of the arts to enable us to discern meanings that would otherwise remain transparent if educators worked only in the linear scientific mode. The stage performance provides a three dimensional

representation of the situation, thereby promoting the holistic involvement of the participants in the meaning- making process. For instance, in the scene where Ana has her hands covering her face, Shannon steps up and puts down her hands and raises her face. When asked why she did this, Shannon says:

I feel like sometimes that's the hardest part, to actually get a patient to open up. I feel like it really isn't going to happen unless someone comes and actually removes her hands. I think that is the whole purpose, to try to get Ana to open up, as the patient, to all the people around her.

In this instance, touching Ana and changing her posture gives Shannon the opportunity to direct the scene to convey her meaning- making to other participants. In making this change to the posture of Ana, a meaning is arrived at from the viewpoint of Shannon. This allows us to see the change in the posture of Ana from one who is covered and helpless, to one open and reaching out for help from those around her. Shannon narrates that she has had a similar experience with a patient of hers. Through the mental representation of her patient, Shannon arrives at her action in the scene with Ana. Her action on stage is triggered by the deep emotion she felt for Ana. This is evident when she says: “I felt bad for Ana”. In this example, Shannon is involved with her mind, body and emotions in the meaning- making process in this scene.

As an arts-based approach to professional development training, Forum theatre provides a platform for participants to arrive at a deeper knowledge of self. Their presence at the training session was not merely physical, rather the totality of their person was involved in the training mind, body, and emotions, thereby facilitating embodied learning. The empowering nature of the use of drama in nurse education, optimally

promotes personal development, self-awareness and potentially, professional efficacy, Wasylo and Stickley (2003). Personal development was evident with Shannon who decided to open up Ana, since she had worked with a similar patient before in reality. This personal development informed her to know that you sometimes need to make the extra effort because the patient is the reason why you are there as the doctor. In her own words the character Ana struck her most “because we're all going to become doctors for the patient. I do think it was the patient and the person that we were kind of supposed to be focusing on”. In personal efficacy, Morgan decides to be calm when carrying out her practice in order to be more efficient. Self-awareness was evident for Teresa when she related the sacrifice by Ana for her child, to the same situation with Teresa’s own parents sacrificing to provide a better life for her.

Jennings (1993), states it best when she says:

The theatre is unique in its capacity to integrate several art forms as well as several aspects of the self. In no other structure can art, music, dance, play, story, and drama come together in a single entity; we are engaged by the juxtaposition of visual images, sounds, movement, verbal statements, at sensory, emotional, and thinking levels.

The constituents of the mind, body and emotions as mentioned above, explain how Forum theatre as a training intervention brings the whole person of the participants in this study to professional development training.

This chapter identifies four major themes which include; mind body and emotions intertwine in meaning-making; the familiar viewed as a new/ different experience; culture as influencer; and social anxiety in learner participation. In presenting these themes, I

included specific vignettes from data collected to illustrate how the mind, body and emotions of the participants resulted in the above mentioned themes.

In mind, body, and emotion intertwining in meaning-making, mental representations prompted learners to arrive at the rationalizing and meaning-making of a scene. This theme speaks to how the mind, body, and emotions, work together in the form of mental representations, physical and verbal actions, and triggered feelings respectively. An instance of this was when Morgan used mental representation to inform her verbal action of stating that the scene when Sarah replaced Dr. Garcia was “calmer”. In expressing this feeling, Morgan relies on her mental representation of the actions of two different attendings she had witnessed in the past. She contrasts both behaviors of the attendings and opts for that which is calmer, as the way she will carry on her practice, because in her opinion it was more efficient. As she says:

Actually I had more than two attendings, but two of them were really, really, really calm in how they ran codes. The codes were so much more efficient. People were not freaking out. They were timing everything right. People were calm and efficient and doing what they needed to do. I think that the leader of the code, or the attending physician essentially set the tone for that by being calm and remaining calm.

The theme of the mind, body, and emotion as being intertwined, explains that mind is present in embodied learning in the form of mental representation; body in the form of actions, and emotion in the form of empathy. This study brings to light, the role of emotional connections in the learning process. It reveals how emotion can serve as a

motivation for people act in given situations to arrive at a desired end. It also reveals the amount of influence that emotion has in the meaning-making process of the learner.

The theme of the familiar viewed as a new/different experience points out how something we are familiar with can take on a different or new perspective when we have that character or instance directly before us, as against just hearing or reading about it. This was the case for John with the character Enrique. John got to have a deeper understanding of the havoc such a character could wreck in one's life. Some other participants began to see the possibilities of arriving at a better treatment for Ana if they included Enrique in the treatment process rather than exclude him. Vignettes from this section explain how the thought process becomes more open to different ways of approaching situations when given a chance to hear other perspectives. This supports Jennings (1987) perspective on Forum theatre as facilitating active learning because it provides a safe context for exploring alternative actions and intervention; offers a fresh perspective on problems and explores a range of possible outcomes.

Culture as influencer gives credence to culture as an underlying necessity to be considered in learning. It provides different contexts through which culture influences doctor-patient relationships and learning situations. Culture was viewed from the perspective of language in communication, sociocultural factors, bridging gaps and managing anxiety. Social anxiety in learner participation points out certain challenges learners may encounter using performance art as a learning tool. This theme reveals how different learners still arrive at meaning-making irrespective of the challenge of social anxiety.

In the next chapter, I will draw on these themes as a basis to understand the contributions of embodied learning to workplace training.

VI. CONCLUSION

In this chapter, I discuss the implications and contributions of the findings from this study as it relates to embodied learning in the field of adult education. I will conclude this chapter by making recommendations for future study. I will also a reflection of my thoughts in partaking of this research experience. As a guiding philosophy, hermeneutic phenomenology was applied to this study for human interpretation (Dreyfus, 1984). In adopting ethnodrama as my methodology, I borrowed ethnographic techniques such as participant observation and interviewing to develop thick descriptions (Geertz, 1973) to interpret how participants shared and negotiated meaning (Glesne, 2016; Cresswell, 2006). Ethnodrama reduced the data collected to what was salient (Saldaña, 2003). As such, the data for this study were collected through various means as interview transcripts, video recordings, video recording transcripts, field notes, and journaling.

The purpose of this research study was to, make concrete the concept of embodied learning in the field of adult education, specifically, medical professional development. It also aimed to identify how the mind, body and emotions contribute to meaning-making. The research questions guiding this study were

- a. How does the mind contribute to meaning-making?
- b. How does the body contribute to meaning-making?
- c. How does emotion contribute to meaning-making?

Summary of Findings

This study reveals theatre as an efficient tool for understanding the embodied learning process and its contribution to meaning-making in the field of adult education.

Boal encouraged citizens to enter the action on stage to rehearse for social change. Spectators who identify with the oppression in the Forum theatre performance, are invited to replace the protagonist and act out their own possible solutions to scenes the play presents, thereby rehearsing action for revolution in everyday life (Bell & Jones, 2008; Cohen-Cruz & Schutzman, 2006; Jackson, 1992). This study contributes to the knowledge base information on embodied learning in the field of adult education, using art in the form of theatre. The perspectives of the participants reveal the role theatre can play in embodied learning.

The study identified empathy as producing a trigger effect of spurring learners into action, through the felt-sense and the body as a lived being. Theatre provided this opportunity for the participants to undergo the process of embodied learning and arrive at their own meaning-making. As a result, the participants “delved deeply” into themselves to arrive at mental representations to further their meaning-making process.

The finding of mental representation in this study from the field of psychology and cognitive science by Boyer and Wertsch (2009); Mayer (2003), and Paivio (1990), introduces the knowledge base of adult education to the world of psychology and cognitive science in relation to embodied learning. In identifying mental representation as a part of the meaning-making process, the role of the mind is more clearly defined, as it relates to embodied learning.

In applying the hermeneutic philosophy to this study, my findings reaffirm my African indigenous cultural perspective as a Nigerian Igbo woman. The very fabric of African life constitutes community, and belonging to a community of people. Social constructionism plays a role in the meaning-making process of the participants. As is

revealed in the findings, participants refer to their cultural background in the interpretation of scenes that they encountered. The culturally inherited meanings in this study arise out of interaction between humans and the realities in their world (Crotty, 2007). My culture as a Nigerian, with knowledge of African theatre, a personal experience in the corporate world, and the field of adult education, creates a fusion of horizons guiding my understanding, which according to (Lawn, 2006), is interpretation.

Sankofa, in the Akan language of Ghana, is often associated with the proverb, “Se wo were fi na wosankofa a yenkyi,” which translates, “It is not wrong to go back for that which you have forgotten” (Allvin, 2014) in other words, return to the source and fetch (learn). This comes to mind for me in this study because theatre provided the platform through which participants return to the source and fetch (learn) to influence the present. The African indigenous perspective contributes to the knowledge base of the field of adult education in understanding how culture contributes to meaning-making. In the words of Achebe (2012), it is very important for writers to be aware of what our African literature achieved, what it has done for us, so that we can move forward.

Implications Emerging from Study

Although embodied learning is present in adult education and has been addressed from the perspective of performance art (Butterwick & Selman, 2012; Nieves, 2012; Snowber, 2012); intuition (Lawrence, 2012), creative writing (Tobin, 2014); patient education (Swartz, 2012), experiential practice (Howden, 2012); spirituality (Merriam, 2012); and workplace learning (Meyer, 2012) just to mention a few. However, Lawrence (2012) identifies embodied learning as the least discussed method of learning in adult education. Tobin and Tisdell (2015), observe that most contributions are more conceptual

as opposed to research studies per se. This reveals a need in the field of adult education to delve deeply into the application of embodied learning, its advantages, and disadvantages. An implication for embodied learning theory in adult education as a result of the findings will be to seek to modify curriculum to accommodate creative instructional styles that tailor to a more holistic style of learning for the growing diverse teaching and learning adult population.

The study findings have several implications for scholars in adult education, embodied learning, workplace learning, and professional development. The methodology and analytic framework, have implications for scholars who may be interested in using arts-based research methods in qualitative research and on embodied learning. Participants in this study expressed a heightened level of conscientization, which Freire (2000), defines as a deepening of the attitude of awareness characteristic of all emergence. The study findings express how embodied learning prompts study participants to look closely into their practice as medical students/ interns. This action roots itself in what Freire (2000), refers to as;

problem-posing education which affirms women and men as beings who transcend themselves, who move forward and look ahead for whom immobility represents a fatal threat, for whom looking at the past must only be a means of understanding more clearly what and who they are so that they can more wisely build the future (p. 84)

As a result, there is a need to look deeper within one's self to arrive at that desired citizen that one strives toward, through education. The platform to look deeper in this study is made readily available through the use of Forum theatre. Embodied learning came to

exist in this training through the implementation of Forum theatre. This prompted the participants to reflect even more deeply on certain actions that they might encounter on a global health trip and their possible reactions to these situations. On the relationship between Forum theatre and conscientization, this study reveals how we can practically apply performance art in a professional development setting to arrive at conscientization. This originates organically through trainee input in the course of the Forum theatre performance. Forum theatre has provided a road map through which we can clearly identify how the mind, body and emotion specifically contribute to meaning making. As a result of this, training practitioners and Forum theatre practitioners can work together to map out an applicable guide to implement these strategies to varied training situations.

Contribution to Practice

This study underscores a need for adult educators to adopt more creative styles of training that encourage the inclusion of the totality of the learner through their mind, body and emotion. In doing this, the concept of banking education will become a thing of the past and as such lead to the creation of training programs with more focus on an embodied learning approach.

Participants expressed the importance of the role of empathy in their learning process. Based on this finding, practitioners engaged in any form of workplace training or professional development could infuse aspects in their training which tailor to the emotions of participants. This will aim to develop a positive and more holistic involvement of participants in the training.

The study findings emphasize the importance of culture as an influencer in learning. Thus, adult education practitioners should ensure that cultural sensitivity is a

factor that is taken into consideration. This cultural sensitivity is not only in the sense of respect for others, but in recognizing that since most people who have English as their second language who have cultures different from that of the West, tend to interpret situations different from their Western counterparts. There is a need for practice to create safe spaces where dialogue can take place to arrive at meaning-making.

Due to the increasing diversity within our educational institutions, and workplaces, adult educators today should recognize their role as *global* adult educators, and as such, be willing to explore more diverse means through which meaning-making can be achieved.

Contribution to Policy

This study reveals a need to modify the status-quo of embodied learning in adult education. Only two participants had heard of Forum theatre prior to this training. Both had heard of Forum theatre outside of the classroom. In addition, participants saw the familiar as different in this study. This draws attention to the importance of policy to acknowledge and adopt more creative training methods. In doing this, more students could be exposed to the possibilities through which learning can take place in a fun way in a learning setting. As Sarah, one of the participants said;

“It was fun. It was interactive; it wasn't sitting out and staring at someone talking for 30 minutes and pointing to a screen. Personally, I have ADHD, so anything that's a little bit more interactive is going to be more fun and helpful, I think. I learn by doing; I don't learn by sitting there”.

The study findings reveal in more depth what happens during the meaning-making process for the adult learner. As a result, there is a need for policy to encourage

the use of art -based research methods in carrying out research. The more often these art-based methods are used, the more concrete certain descriptions of learning processes can be expressed and understood to inform the field of adult education.

Policymakers should encourage academic collaborations that lead to the breaking of silos, and inter-professionalism, which could further promote a sharing of knowledge with other academicians from diverse fields. This could lead to findings beneficial to all academic fields involved.

Limitations

This study focused on fourth year medical students. Due to its focus on medical training, the results implicated in this research may not be applicable to a different workforce training situation. I was acutely aware of my role as actor in the play and as researcher in the study. Although this may have given me greater access to participants, I acknowledge that there might have been certain aspects of the study that I may have missed even though an assistant aided me in recording the performance. For instance, there were certain ongoing side comments that participants made during my time on stage that I was unable to hear, which if I was sitting in the audience I may have heard and included in my, field notes, and may have served to be included in the interview sessions.

Recommendations for Future Research

Since this study looks at fourth year medical students as they go into their residency, a follow-up study on transference could be carried out to determine whether they carried on with what they learned from the training and if they continued positive practices they portrayed at the training to residency, and their global health practice.

This study focused on the medical profession, however a future study could look at a workplace situation that is different from the medical field. This study focused on adult learner's actions and reactions to what they saw on stage to understand their meaning-making. A future study could be focused on the actors involved in the play such that we try to understand their own meaning-making in relation to the changes made by the spect-actors. For instance, understanding how changes made by Mumini to Enrique (the boyfriend) affects Enrique's own meaning-making. Future studies focusing on describing and explaining the process of embodied learning in adult education could be carried out to make this theory less conceptual and more concrete for adult educators and learners.

Concluding Thoughts

In portraying the character Ana, I underwent a form of embodied learning of my own when a participant asked the character Ana "Do you think you can get help finding a different job, or finding some way to make money through your mum...? I was immediately struck at how easy it must seem to the outsider to swoop in and proffer a solution. I felt this was a slight on the character Ana. I empathized with the character Ana and was quite angry at the question she was asked. I had a mental representation of a friend of my sister who lived with my family growing up. She was from a financially challenged background while involved in an emotionally unstable relationship. She lived with us for a number of years. She was treated like family and eventually, left to establish herself. I remember rationalizing the character Ana's response from this perspective. This young lady had thought about all her options before she spoke to my sister about her situation. My sister in turn tried to assist her.

I thought to myself that most times people stay in certain deplorable situations not because they enjoy it, but most times because, that is all they are familiar with, they see no options, and identify that they have no way out of their current situation. Rather than ask questions that make it seem like they have not thought through their situation, why not ask what they think would be most helpful to their current situation. Although things are not a breeze for this young lady today, they are definitely a lot better than they were when we first met her. She has better job options than before. This mental representation prompted the response that Ana gave to the question she was asked, saying “This is Santo Domingo, where do you want me to get the money from? This is what I know. This is all I know. This is the best I can do”.

Wagner and Shahjahan (2015) remind us that, despite the benefits of embodied learning, introducing embodied learning activities in the contemporary neoliberal context of higher education is fraught with challenges and risks depending on the social position of the instructor. With a background in dramatic arts and workplace training, I can identify opportunities that art provides for embodied learning in the workplace. Although statements like that of Wagner and Shahjahan (2015) on the “challenges and risks” remind me of the dominant Cartesian mind and body dualism existence, scholars who reinforce the use of embodied learning provide me with a hope on the many possibilities that embodied learning avails me as an adult educator. Tobin and Tisdell (2015) acknowledge that studying the process of embodied learning is complicated. They leave it to other researchers to put more meat on the bones of embodied learning in adult education. I am hoping that my interest in exploring embodied learning in more depth will contribute some meat to its existing bones in adult education.

APPENDIX SECTION

Appendix A

Informed Consent

Study Title: Embodied learning as a tool for meaning making: A Forum theatre training.
Principal Investigator: Chinedu Anumudu /APCE, Texas State University
Sponsor: N/A

This consent form will give you the information you will need to understand why this research study is being done and why you are being invited to participate. It will also describe what you will need to do to participate as well as any known risks, inconveniences or discomforts that you may have while participating. We encourage you to ask questions at any time. If you decide to participate, you will be asked to sign this form and it will be a record of your agreement to participate. You will be given a copy of this form to keep.

PURPOSE AND BACKGROUND

You are invited to participate in a research study to learn more about embodied learning in adult education. The information gathered will be used to describe how the mind, body and emotion contribute to meaning making changes in an embodied learning process. You are being asked to participate because you are adult learners that will be involved in a forum theatre training that will be carried out by the organization.

PROCEDURES

If you agree to be in this study, you will participate in the following:
Two thirty minute interviews and One thirty-minute participation in the forum theatre performance

- One 30 minute interview about your expectations and perspectives going into this form of training
- One 30 minute participation in the forum theatre performance
- One 30 minute interview about the role of the mind, body and emotion in the learning process

We will set up a time for you to meet one of the investigators at the location of the training or at a site of your choosing that is most convenient and comfortable. The first 30 minute interview will be prior to your participation in the Forum theatre training. The purpose will be to determine the expectations and perspectives. The second interview will be an informal conversation at the time you participate in the Forum theatre performance, and its purpose will be to identify the specific actions that represent the moments of change that occurred in the Forum theatre performance. The third interview will be after the Forum theatre performance and its purpose will be to determine how

the body, mind and emotion contributed to the meaning making changes that occurred during the course of the Forum theatre performance.

If you agree to be in the study, you will be asked to participate in two interviews of approximately 30 minutes before the performance and after the performance. You will participate in informal conversations with the researcher at the time of the Forum theatre performance. During the interviews, you will be asked about your expectations, participation, and experience of Forum theatre, particularly pertaining to your learning process. The interview will be (audio-recorded) and the researcher may take notes as well.

RISKS/DISCOMFORTS

In the unlikely event that some of the survey or interview questions make you uncomfortable or upset, you are always free to decline to answer or to stop your participation at any time. Should you feel discomfort after participating and you are a Texas State University student, you may contact the University Health Services for counseling services at list 512 245 2208. They are located 5-4.1 LBJ Student Center 601 University Drive, San Marcos, Texas 78666

BENEFITS/ALTERNATIVES

There will be no direct benefit to you from participating in this study. However, the information that you provide will provide adult educators a more concrete means through which embodied learning can be applied to training adult learners. The study results will be shared with you, and as an educator, the findings regarding learning may be of interest to you.

EXTENT OF CONFIDENTIALITY

Reasonable efforts will be made to keep the personal information in your research record private and confidential. Any identifiable information obtained in connection with this study will remain confidential and will be disclosed only with your permission or as required by law. The researcher, the researcher's dissertation chair, and the Texas State University Office of Research Compliance (ORC) may access the data. The ORC monitors research studies to protect the rights and welfare of research participants.

Your name will not be used in any written reports or publications that result from this research. Data will be kept for three years (per federal regulations) after the study is completed and then destroyed.

COMPENSATION

You will not be paid for your participation in this study.

PARTICIPATION IS VOLUNTARY

You do not have to be in this study if you do not want to. You may also refuse to

answer any questions you do not want to answer. If you volunteer to be in this study, you may withdraw from it at any time without consequences of any kind or loss of benefits to which you are otherwise entitled.

QUESTIONS

If you have any questions or concerns about your participation in this study, you may contact the Principal Investigator, Chinedu Anumudu: 951-332-1980 or cca28@txstate.edu.

This project 2017229 was approved by the Texas State IRB on November 21, 2016. Pertinent questions or concerns about the research, research participants' rights, and/or research-related injuries to participants should be directed to the IRB Chair, Dr. Jon Lasser 512-245-3413 – (lasser@txstate.edu) or to Monica Gonzales, IRB Regulatory Manager 512-245-2314 - (meg201@txstate.edu).

DOCUMENTATION OF CONSENT

I have read this form and decided that I will participate in the project described above. Its general purposes, the particulars of involvement and possible risks have been explained to my satisfaction. I understand I can withdraw at any time.

_____	_____	_____
Printed Name of Study Participant	Signature of Study Participant	Date
_____	_____	
Signature of Person Obtaining Consent	Date	

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