Power, Privilege, and Allyship
Core Didactic Series
Excerpt; not full slides; 5 pages

Session #1: Power Hierarchy

Power, Privilege, and Allyship

1

DRAW

Consider all the members of the interdisciplinary team on the inpatient units at ____. Draw your perception of the HIERARCHY among the different members.

IN YOUR BREAKOUT GROUPS…

- Share screen → select white board
- Draw the hierarchy!
- Save your work (click "save") to present back to group

2

Power Hierarchy Discussion

- *Small groups shared their drawings of the power hierarchy. We then shared drawings of the power hierarchy collected from other interdisciplinary staff members: nurse, nurse manager, attending, social worker, unit secretary, medical director. We discussed similarities and differences.*
- *Drawings removed from this teaching sample for privacy*

3

Some ideas about power

- **Basic Definition:** Ability to act or produce an effect, or in social science "capacity of an individual to influence the behavior of others."
- Relational (Nye)
- Not all power is equal (French and Raven)
- Based in part on perception (Guerrero and Anderson)
- Neutral vs. Coercive
- Enabling and Constraining (Foucault)
- Social Power: "the ability of an actor to change the incentive structures of other actors in order to bring about outcomes" (influence choices, knowledge of choices, observable outcome) (Rational choice framework, Lukes)
- Power distance

4

CASE

A PGY-2 resident feels demoralized and confused after an encounter with nurses. Earlier in the day, she and her attending had made the difficult decision to discharge a patient from __. The patient was clearly suffering and did not want to leave but did not seem to be benefiting from inpatient treatment. Moreover, there was concern that ongoing medicalization of symptoms was hindering the patient's progress. After rounds, the attending left and the resident placed the discharge order. While she was working on the discharge summary, three nurses came into the workroom to express concern. They told her that the patient was still very sick, repeated things the patient had told them about why she couldn't leave and insisted that the medical team reconsider the discharge. Afterward, the resident felt "caught in the middle" and maybe even a little "bullied."

DISCUSS.

5

Closing questions

Over the next week, notice/reflect:

- When do you feel powerful, empowered?
- When do you feel powerless, disempowered?
- How do you respond when you feel powerless?
- When do other people seem to attribute power to you?
- When do you attribute power to others?
- What about your personal journey and life history have informed your take on this?
- What are some of the different types/sources of power that people have?

6

Some Theories of Power

- Basic Definition: ability to act or produce an effect, or in social science "capacity of an individual to influence the behavior of others."
- Relational (Nye)
    - Inherently relative. Requires a dynamic between A-B.
- Different types (French and Raven)
    - Legitimate: power gained through delegation/authority. This power is formal and recognized. E.g. power via position as CEO
    - Coercive: power obtained through force, threats, and/or punishment for noncompliance. This type can generate resentment, resistance, and a lack of formal recognition
    - Referent: power based on charisma and ability to attract others, inspire loyalty, and shape outcomes. E.g. sports figures
    - Reward: power gained via ability of person A to compensate person B for compliance
    - Expert: power gained via one's skill or knowledge
    - Informational: power gained via one's ability to control/dispense information that others need
- Based in part on perception (Guerrero and Anderson)
    - Regardless of the type of power someone holds, their ability to utilize it or make it meaningful depends in part on perception. E.g. not all those with legitimate power are able to wield it (may not be able to command respect or sway others). Not all those with referent power are able to affect an outcome without formal authority.
- Neutral vs. Coercive
    - The way in which an outcome is enacted can be incentivizing, neutral, or coercive
    - Incentivizing: offering rewards or gains
    - Neutral: friendly offer or encouraging empowerment in others
    - Coercive: via negative influence, e.g. violence, threats, withholding of rewards
- Enabling and Constraining (Foucault)
    - Foucault said that power is a structural expression of complex societal dynamics that require both constraint and enablement.
    - E.g., placing an involuntary psychiatric hold as a constraining measure, in-hospital legal hearings as an enabling measure
- Social Power: "the ability of an actor to change the incentive structures of other actors in order to bring about outcomes" -- influence choices, knowledge of choices, observable outcome (Rational choice framework, Lukes)
    - Power can be about using influence to maximize benefit, not just in observable outcomes but also in the ability to influence what choices people have and to what extent they are aware of their choices.
    - E.g. when we give patients medication options for sleep, we may not offer some medications (e.g. may offer Trazodone or Doxepin, but not Ambien)
- Power distance
    - Strength of the social hierarchy. The extent to which less powerful people in a society accept that power is distributed unequally.
    - E.g. if you have a high-power-distance framework, you might see a lot of social, decision-making and problem-solving space between you and your attending.
    - E.g. if you have a low-power-distance framework, you might feel that these relationships are, in general, more equal and collaborative.

Session #2: Privilege

Privilege (one type of power)

- *Showed two videos providing definition of privilege*
  - _____
  - _____
  - *Video that we created ourselves with "whiteboard-style" animation. Script on next slide.*

7

Let's talk about privilege.

I know, I know. Talking about privilege can make some people uncomfortable due to its use in familiar phrases like "white privilege" and "check your privilege," which can suggest certain people are to blame.

But our goal today is not blaming or shaming. Although talking about privilege can incite feelings of anger, guilt, discomfort or even desire for avoidance, it is important for us to have this conversation.

Where did the term white privilege come from?

In the 1980s, the scholar Peggy McIntosh wrote an essay entitled White Privilege: Unpacking the Invisible Knapsack. In this essay she reflected upon her personal life experiences to develop a list of rarely noticed advantages, based on the color of her skin, that she benefits from on a daily basis. For example,

- "I can go shopping alone most of the time, pretty well assured that I will not be followed or harassed."
  "I am never asked to speak for all the people of my racial group."
  "I can turn on the television [...] and see people of my race widely represented."

She described privilege as an invisible and weightless backpack of unearned special provisions such as maps, tools, and blank checks that she could count on cashing in each day, and that she had previously taken for granted. Her work sparked the investigation and study of the concept of privilege in academia.

When we talk about privilege today we are not just talking about race.

Privilege can be based on many different advantages such as: gender, physical ability, education level, sexual orientation, socioeconomic status, and language. All of these can convey benefits that were not earned by a person's individual effort or talent.

In fact privilege can be defined as: an unearned right or advantage given to an individual simply because they are a member of a dominant social group. Privileges are often invisible to those that have and benefit from them.

It is important to know that no matter who you are, EVERYONE has some types of privilege, and does not have others. And, privilege isn't any one person's fault, but rather the product of an unequal society. And, once we know about it, we can work together to overcome it.

What's your privilege?

8

Reactions?

- How does this sit with you?
- What do you like about it?
- What don't you like?
- What emotions come up?

9

REFLECTION

White Privilege in a White Coat: How Racism Shaped my Medical Education

Max J. Romano, MD, MPH
MedStar Franklin Square Medical Center, Baltimore, Maryland

Annals of Family Medicine
May/June 2018

10

CASE (from last week)

A PGY2 resident feels demoralized and confused after an encounter with nurses. Earlier in the day, she and her attending had made the difficult decision to discharge a patient from __. The patient was clearly suffering and did not want to leave but did not seem to be benefiting from inpatient treatment. Moreover, there was concern that ongoing medicalization of symptoms was hindering the patient's progress. After rounds, the attending left and the resident placed the discharge order. While she was working on the discharge summary, three nurses came into the workroom to express concern. They told her that the patient was still very sick, repeated things the patient had told them about why she couldn't leave, and insisted that the medical team reconsider the discharge. Afterward, the resident felt "caught in the middle" and maybe even a little "bullied."

How might people's identities/privileges impact the power dynamic in this interaction?

11

Closing questions

Over the next week, notice/reflect:

- What interpersonal power dynamics do you encounter?
- What emotions come up for you?
- What types/sources of power do you notice?
- What privileges do you experience (or not experience) in your daily life?
- What do we do? (more next week!)

12

Session #3: Allyship

What is allyship?

- An active, consistent, and arduous practice of unlearning and reevaluating, in which a person who has privilege seeks to act in solidarity with a marginalized group
- Since everyone holds systemic power/privilege in some areas and lacks it in others, everyone has areas in which they can practice allyship, and areas in which they might seek out an ally

Allyship as a skill, a practice, a process

Anti-Oppression Network: https://theantioppressionnetwork.com/allyship/
University of Florida Counseling and Wellness Center, BAM! Best Allyship Movement: https://counseling.ufl.edu/resources/online/bam/part-4/#skills

13

Addressing Bias We See: Bystander or Upstander?

Bystander
"Present but not involved; spectator; onlooker"

Upstander
"One who speaks up and becomes involved"

Upstander (active bystander) methods can vary in style:

Direct
The upstander intervenes or addresses the behavior as it occurs

Follow-Up
The upstander follows up and supports the target

As presented by _____ 8/28/20
Mello and Jagsi, 2020, New England Journal of Medicine. Standing up against gender bias and harassment – a matter of professional ethics.

14

Applying Upstander Strategies

Be Literal
"That stereotype doesn't really make any sense."

Ask Questions
- *"Why do you think that's funny?"*
- *"What did you mean by that?"*

Direct Communication
"We treat every patient here with respect regardless of their race (or ethnicity, gender…) and we expect to be treated with the same respect."

State Discomfort
"That comment makes me uncomfortable. It could be perceived as racist (or sexist)."

Adapted from: [1] Ohio State University, Kirwan Institute for the Study of Race and Ethnicity; [2] Stanford Hospitals and Clinics: Ann Weinacker/Megan Mahoney; [3] Mello and Jagsi, 2020, *New England Journal of Medicine*. Standing Up against Gender Bias and Harassment — A Matter of Professional Ethics

[redacted]

As presented by _____ 8/28/20

15

Indirect/Follow-Up Strategies

Remove the target from the situation	*"Mr. King, I'm going to have Dr. Target assist with another patient."*
Provide support privately to the target of the behavior	*"I thought what he said was unacceptable, and I'm really sorry it happened. How are you doing? What can I do to support you?"*
Express disapproval of the behavior to the perpetrator in a private setting	*"We do not tolerate that type of language in our hospital."*

As presented by _____8/28/20
Mello and Jagsi, 2020, New England Journal of Medicine. Standing up against gender bias and harassment – a matter of professional ethics.

16

Small Groups

- *Split audience into three small groups*
- *Each small group received a different scenario and the discussion questions on the right*
- *Then discussed as large group*

Discuss:
- What emotions would you experience in this moment?
- What power dynamics and sources of privilege can you identify?
- What factors are you weighing as you decide if and how to respond?
- **What would you do?**

17

Scenario #1

You are working on __. You are thinking about applying to fellowship and are hoping to ask your inpatient attending to write you a letter of recommendation.

One day, you and your attending go to see your patient, who is a 22yo trans woman recovering from a manic episode. As the team is interviewing the patient and discussing discharge planning, she tells you that she would like to explore starting hormones and asks for more information about this before she leaves. Your attending sighs and says, "you're just coming out of a really stressful time. Your body and mind are still vulnerable. Maybe before you start thinking about all that you should just try to make do with what you've got, okay?" The patient looks dejected. As you leave the room, the attending tells you, "He is NOT ready to make those kinds of decisions."

18

Scenario #2

You are a resident on __evening tandem call with one of the new interns. It is her third tandem call, and you are hoping to let her do everything on her own. You receive an ED consult and go to evaluate the patient. As you enter the room, the patient says "Oh honey, I didn't ask for the nurse" before the intern can introduce herself. The intern laughs uncomfortably and attempts to continue the interview. The patient is pejorative and combative throughout, and about 10 minutes later abruptly says " *** [racial slur], I'm done with you" to the intern.

19

Scenario #3

You are an intern during your first week on the ___ unit. One day, you are in the workroom with a medical student and the PGY2, trying to catch up on notes. A nurse comes into the workroom to tell you that one of your patients is feeling anxious. After the nurse leaves, the PGY2 laughs and says, "that happens all the time!" The PGY2 then pretends to pick up the phone, imitates a Mexican accent, and in broken English says, "doctor, doctor, the patient is anxious, can you come to see them?" The medical student looks at you.

20

Closing questions

- What interesting power dynamics have you noticed?
- What have you noticed about your own power / privilege?
- What emotions have come up? What has been especially potent?
- What didn't we cover that we should have covered?
- What does allyship mean to you?
- What are some situations…
  - …in which you wished someone else had acted as an ally for you?
  - …in which someone did act as an ally?
  - …in which you wanted to act as an ally but weren't sure how to do it?

21

Gender-Affirming Care
Inpatient Psychiatry Didactic
Excerpt; not full slides; 2 pages

Gender-Affirming Care: Skills & Practice

1

Stigma and Discrimination

- 30% lost their job/were denied promotion/were mistreated at work
- 47% were victims of sexual assault
- 77% were harassed or bullied in school because of being perceived as transgender

2

Stigma and Discrimination

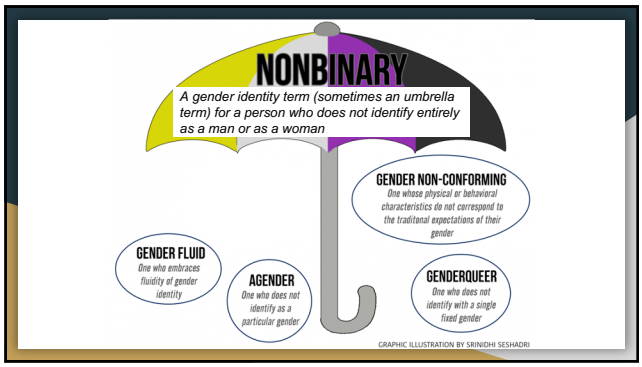
- 40% had a suicide attempt (compared to 4.6% of US adults)
- 29% used drugs/alcohol to cope
- 57% reported feeling uncomfortable asking for help of police if needed
- 32% limited the amount they ate and drank to avoid using a public restroom

3

Terms to describe gender identity

INSTEAD OF THIS	TRY THIS
transgendered, transsexual	transgender, trans
sex, biological sex, real sex, bio male, bio female	assigned male at birth (AMAB), assigned female at birth (AFAB)
MTF, male-to-female, "born as a man"	trans woman, woman
FTM, female-to-male, "born as a woman"	trans man, man

4



5

6

How do you ask about gender identity?

- Tips:
  - Don't assume gender based on appearance/name/pronouns
  - Mirror the language the patient chooses
- Examples:
  - "If you feel comfortable sharing, what is your gender identity?"
  - "How would you describe your gender identity?"

7

How do you ask about pronouns?

- Tips:
  - Practice
  - Avoid using the term "preferred pronouns"
  - Avoid calling pronouns "male" or "female"
  - If/when you make a mistake, briefly apologize and move on
- Examples:
  - "I'm Dr. X and my pronouns are she/her"
  - "What are your pronouns?"
  - "What pronouns do you use?"

8

How do you navigate names?

- Tips
  - Ask what name a person wants you to use
  - Avoid saying deadname aloud in essentially all situations
    - E.g. "I knew Jay when he was Jenny"
  - Avoid using terms such as "real name" or "preferred name"
- Examples
  - "What name do you go by?"
  - "I knew Jay when he was a teen"

9

Role play: ED Patient

ROLE: CLINICIAN	**ROLE: PATIENT**
- You get paged by _____ while on call - ER resident says: "Brian is a 24yo M who is suicidal" - One prior note mentions patient is "transsexual" but does not have any other details - Task: introduce yourself to patient and begin collecting HPI. Practice your new skills for gender affirming care re navigating names, pronouns, and gender identity terms!	- Your birth name is very triggering. You go by Christy and identify as a trans woman. Your pronouns are she/her - You were physically assaulted recently by an ex (Jamie, uses they/them pronouns) and ever since have been having thoughts of overdosing on your meds - You have had many negative healthcare experiences and are feeling very nervous about this interaction as well - Task: talk to the psychiatrist on-call.

10

Role play: Multidisciplinary Rounds

You are preparing to present a new patient at multidisciplinary rounds. In the morning you read the overnight resident's signout, which includes: Brian S, 24yo MTF with schizophrenia and CAH to kill himself

You go to meet the patient quickly before rounds. The patient tells you:
My name is Bee. My birth name is very triggering. I identify as non-binary and use they/them pronouns.
I have a history of schizophrenia. My parents kicked me out of our home recently, and ever since then I haven't been able to take my meds. My voices are getting worse and I've been having suicidal thoughts.
The voices started telling me to go to the _____, so I decided to come to the ER.
I've been staying with my friend Jay. Jay identifies as genderfluid and uses she/her pronouns.
I've had a lot of negative healthcare experiences and am pretty worried about being in the hospital. This is my second time here.

Role play in pairs:
Present an HPI in MWF rounds for Bee (add in other clinical details or history if you want)
Practice using Bee's and Jay's pronouns, avoiding using Bee's birth name

11

Role play: Reflections

- How was the experience?
- What did you notice?
- What did you find more challenging? What did you find less challenging?
- What questions or concerns does this bring up for you?

12

Psychotherapy Nuggets Series
Inpatient Psychiatry Didactics
3 pages

Safety Planning (powerpoint)

PSYCHOTHERAPY NUGGETS:
SAFETY PLANS

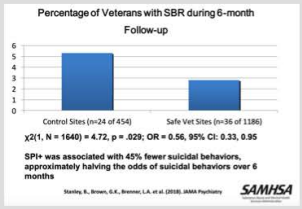
[redacted]

6/30/20

1

SAFETY PLANS

- A **personalized, practical, step-by-step** plan that patients can use to stay safe in the face of recurrent SI/urges
- Rationale
  - Problem–solving and coping skills diminish during intense emotional distress
  - "Coping ahead" can increase resilience/skills during distress
  - Can build a sense of hope, for both pt & provider
  - Evidence-based: ↓ suicide attempts and other behaviors (vs "contracting for safety," which does not)



2

https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pdf

(First link if you google "suicide safety plan")

3

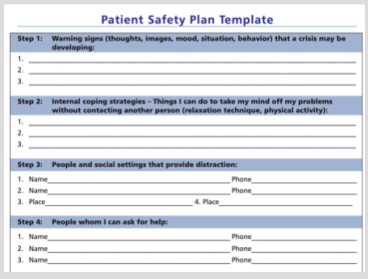
[redacted] TIPS

- Print it out!
- "Planning for the future"
- "Step by step"
- Can give to them, then f/u next time
- What if pt has trouble coming up with content?
  - → "That's OK! Shows us what might be helpful to work on"
- What if YOU have trouble coming up with content?
  - → we'll discuss @ end if time
- Even if you don't do full plan… can use to structure your thinking re how to support pts

4

LOW-KEY ROLE PLAY

- First person: sections #1-2
- Second person: sections #3-4
- *PROMPTS (gave these verbally)*
  - *Try to be "medium resistant" to the idea*
  - *At some point, say something like "I can't think of anything"*
  - *At some point, say "what's the point of this?"*



5

IF TIME: BRAINSTORMING AN "INTERNAL COPING SKILLS" LIST

6

Introduction to DBT and Validation (chalk talk; my speaker notes provided here)

Intro

- What do you know about DBT?
- What questions do you have about DBT?
- Plan
    - DBT concepts that I have found helpful/applicable
    - A few key DBT skills
    - Helping people access DBT
    - Incorporate some of the style/techniques that DBT group therapists often use

Biosocial theory

Bio:

- Natural range of people's internal emotional experience
    - Some with low sensitivity, low reactivity; definitions for each
    - Some with high sensitivity, high reactivity; definitions for each
    - Personal example
- Nowhere along this spectrum is bad or good; part of the natural diversity of human experience
    - Different challenges depending on where we are; provide examples

Social

- = impact of the environment, specifically "invalidating environment"
- Define invalidating environment
    - Examples: childhood abuse, homophobic community, structural racism; not sufficiently attuned aka "not good enough" parent a la Winnicott
    - Damaging for all, but especially for those with higher emotional sensitivity/reactivity
    - Environment reinforces emotional dysregulation/escalation

Bio + Social → <u>emotion dysregulation</u>

- Lack of opportunity to learn skills to regulate → when overwhelmed, act less adaptively
- Brainstorm together: less adaptive behaviors you've observed
    - Eg self-harm/SI, disordered eating, substance use, yelling, calling ex-girlfriend 20x, etc
- Behaviors work in short-term but less well in long-term=

Dialectics

- = Holding two opposites to be true at the same time
- <u>Example: Acceptance & Change</u>
    - All people at any given point in time are doing the best they can
    - All people need to do better and try harder
    - (Personal example, patient example)

Validation

- #1 recommendation for what to try on inpatient
- Powerful; can do in every interaction.
- Also can be hard. People who have been invalidated a lot in their life often end up invalidating others
    - *(Psychodynamics: projective identification!)*
- Within dialectic of acceptance & change…

    - Validation = acceptance
    - We are NOT saying people don't need to change, but we are saying "I see you, I hear you," and something about your perspective makes sense.
- <u>Validation actually → deescalates, decreases emotional intensity</u>

WHAT TO VALIDATE
- The valid, Not the invalid
    - *You must have felt so overwhelmed vs no big deal that you eloped from the unit*
- The facts of the situation
    - *Your mom threw away your pills*
- A person's experiences, feelings/emotions, thoughts about something

HOW TO VALIDATE
6 levels. Aiming for the highest level possible
1. Pay attention with full awareness; stay awake
2. Reflect back
    a. Repeat back
    b. Nonjudgmental tone, check with person
    c. So what was upsetting is your mom threw away the pills without asking you first. Is that right?
3. Respond to nonverbals
    a. You look upset and tired, can I get you some water?
4. How person's behavior makes sense in terms of past (learning hx or biology)
    a. It makes sense that you ____ because _____
    b. It makes sense that you felt angry because of all the times in the past that your mom hasn't asked you for permission
5. How person's behavior makes sense in current context, and demonstrate it
    a. "You're right! ____"
    b. Of course you felt overwhelmed that day, it's hard having to say goodbye to your old doctor and meet a new doctor. Is there anything I can do to help with the transition?
6. "Radical genuineness"
    a. Treating someone as true equals and full humans
        i. Not fragilizing them, not being patronizing/condescending
    b. Be genuine and authentic
    c. Apologize/admit for mistakes, be willing to be corrected

Wrap-up
- Quick intro to DBT structure: individual, skills group, phone coaching
- Local DBT resources
- Helping people who might be hesitant about DBT: let's brainstorm a "pitch" together