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Should We Talk about the Pain? Personalizing Sociology in the Medical Sociology Classroom

Alexandra C. H. Nowakowski[1] and J. E. Sumerau[2]

Abstract

This article discusses the potential of personalizing sociology curriculum, specifically in Medical Sociology courses, to increase student engagement and sociological awareness. Based on our experiences offering separate Medical Sociology courses at a large public research university and a small private teaching university, respectively, we outline emotional techniques we have each employed—separately and together—in our classes to facilitate student engagement, critical awareness, and medical coming out processes in our classrooms. In so doing, we have both built highly successful and popular Medical Sociology courses where students learn about and engage with the interpersonal and emotional effects of health care systems, structures, and patterned disparities. Throughout this article, we use our experiences as a case for facilitating debate concerning the incorporation of personal and emotional biography into sociological teaching and provide questions that may facilitate such conversation. In closing, we encourage sociologists to reflect upon, consider, and debate the usefulness of incorporating personal and emotional biographies into the curriculum.

Keywords

critical pedagogy, emotions and teaching, inequalities, medical sociology

> As an adolescent, I endured years of chronic pain as I watched my body wither into frailty. I sought medical care from numerous specialists, with few enlightening results. Instead, I received a slew of erroneous and incomplete diagnoses—or worse yet, blame for my own failing health. This continued until age 23, when I was admitted to intensive care and told that I would likely not survive the night.

> When I was a teenager, I slowly realized that I don't remember much of my first 12 years, that I could hear voices in the back of my head, that I didn't see the same colors or world other people saw, and that I would bounce back and forth from wanting to kill myself to thinking I was literally unbreakable. Terrified, I went with my sister to see a mental health specialist who admitted he had no clue what was going on in my brain.

At the start of any given semester, students in two different schools will hear a version of one of these stories. In the former case, the first author will use her medical experiences to introduce medical sociology to approximately 70 undergraduates of varied races, class backgrounds, and majors at a large

[1]Florida State University, FL, USA
[2]University of Tampa, Tampa, FL, USA

Corresponding Author:
Alexandra C. H. Nowakowski, Florida State University, College of Medicine, COM 4114, 600 West College Avenue, Tallahassee, FL 32306, USA.
Email: xnowakowski@fsu.edu

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public research university. In so doing, she will talk about the late nights vomiting for no apparent reason; the difficulties sleeping, standing up, or going to school when her body just said no; the countless experiences she had with confused medical authorities and systematic though unhelpful testing; and the ways people occasionally see her less than 100 pound body and make assumptions about who she is and how she should be treated that do not fit the well-educated, successful, socially active leader she actually is.

In the latter case, the second author will use his medical experiences to introduce medical sociology to approximately 25 undergraduates of varied races and majors despite mostly homogenous class backgrounds at a small private teaching university. In so doing, he will talk about the times friends held him in place so he couldn't kill himself, the time he thought he could jump from one building in Manhattan to another, the endless rounds of pills and therapeutic techniques that offered no help and the sadness that came with repeatedly crushed hopes, and the ways he still has to figure out whether what he sees is real or not on a daily basis.

In both cases, students will—like fellow researchers and students in other courses when we have shared similar experiences as guest speakers, conference presenters, or workshop members—stare enraptured with faces conveying empathy, worry, fear, and/or sadness as we tell our stories. Further, our stories always generate immediate curiosity and engagement wherein students can't ask all the questions they have fast enough and where at least one will thank us—often in tears—at the end of the first class meeting for already—before covering any material—teaching them they are not alone. Finally, as we continue to share our own and each other's experiences throughout the semester, we will observe both continued levels of high engagement and more students opening up—with us and their classmates—about the many ways social factors influence their own health, well-being, and health care experiences.

Although we have experienced tremendous success using emotional and personal experiences in the classroom, this practice stands in stark contrast to the lessons we received in graduate programs encouraging us to remain distant or non-emotional in classrooms and at conferences (see Blouin and Moss 2015 for the current state of teacher training and teacher norms in sociology). While conferences and graduate programs explicitly call for distancing ourselves (and our personal experiences) from the subject matter (see also De Welde, Stepnick, and Pasque 2014), our own experiences within classrooms suggest sharing personal and emotional stories from our own lives are often incredibly useful for us and students (see also Adams 2010; hooks 1994). In this article, we thus ask sociologists to consider the usefulness of incorporating their own biographies into the curriculum.

To this end, we share experiences that have taught us that doing so may facilitate translating scientific research into meaningful realities for our students. In so doing, we outline some ways we personalize scientific findings in our medical sociology courses to provide other teachers with examples for debating the benefits and limitations of incorporating instructor biographies in ways that may help students recognize that "the personal is political" (Kleinman 2007) as well as sociological (Greenfield 2006). We thus share elements of our own medical narratives (Rier 2001) to suggest some ways personal experiences may be used to bring medical sociology to life for our students and facilitate conversation on the potential of such tactics.

Our discussion thus speaks to longstanding debates concerning the role of personal and emotional experience in classroom encounters and curricula (see e.g., Freire 1968; hooks 1994; Lucal 2015). While traditional educational models—as well as the graduate programs and conference workshops we attended—encourage instructors to establish distance from both their subjects and their students in academic work (Blouin and Moss 2015), scholars have regularly noted the utility of engaging student biographies and experiences in classroom instruction, especially in the case of minority and diverse student populations (Freire 1968; Greenfield 2006). Incorporation of instructor biographies, however, has received less discussion among scholars even though they may also provide useful mechanisms for student engagement and awareness (Adams 2010; hooks 1994). We thus seek to encourage debate about the incorporation of instructor biographies in sociological classrooms by demonstrating some ways that doing so has allowed us to generate student awareness, engagement, and application of sociological content in concrete ways.

PERSONALIZING TEACHING

As Greenfield (2006) notes, scholarly traditions tend to privilege cognitive rather than emotional approaches to education and instruction. In so doing, college education tends to marginalize the

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role of emotions in learning, retention, and other ways of knowing (Heron 1992). When we ask our students about health and medicine each semester, however, they typically respond with emotional concerns, memories, and experiences related to health care and health professions before noting any kind of cognitive reason for taking our courses. In this way, our students mirror potential social movement recruits (see Schrock, Holden, and Reid 2004) by being drawn into health-related majors, occupations, courses, and programs through emotional rather than rational means. As such, providing students with opportunities and languages to utilize emotion for learning and comprehension may be imperative (see also Greenfield 2006).

To this end, we built our courses—individually first and later collectively—around emotional narratives, or personal stories that capture and evoke emotional responses from others (see Fields, Copp, and Kleinman 2006). In so doing, we took lessons from critical traditions exploring women's (Kleinman 2007), racial minorities' (Collins 2005), and sexual minorities' (Warner 1999) experiences with structural inequalities in hopes of providing students with a model for expressing reactions and histories with both social structures and course materials (see also hooks 1994). As researchers and teachers committed to critical theories (Collins 2005) and pedagogies (Freire 1968), we understood that all personal experiences (including those of instructors) have political and sociological causes, consequences, and influences. As people who had faced structural inequalities and traumatic events, however, we also understood how hard it can be to talk about the pain such experiences cause both in the moment and throughout the life course. We thus incorporated our personal biographies into the curriculum to provide students with an actual example of structural impact they could relate to, touch, and see in the form of our own respective and shared medical histories (see also Rier 2001).

Seeking to build critical understandings of society for our students, however, we did not limit our disclosures to medical issues. Rather, we incorporated the ways our biographies responded to our locations in interlocking systems of privilege and oppression. While we both appear white, for example, we each come from a mixture of indigenous and other ethnic histories. Similarly, while our life partnership suggests heterosexuality, the first author identifies as heterosexual-queer by embracing and affirming sexual fluidity in her life and that of others, and the second author has lived openly as a bisexual for over two decades and faced harassment as a result of his same-sex relationships. Further, while we both hold advanced degrees and professorships, the first author works extensively with lower-class communities on health-related interventions while the second author spent much of his life in the lower working class. Finally, while we possess bodies currently defined as female and male, respectively, we both embrace genderqueer identities and self-presentations, and the second author almost transitioned into a female in his early adulthood. Rather than limiting our disclosures to medical concerns, we use our situated biographies (hooks 1994) to de-naturalize racial, classed, gendered, and sexual assumptions for the students in our classes.

Building on this background, we outline some ways we use personal stories to facilitate student engagement, critical awareness, and medical coming out processes in our classrooms. Before presenting this information, we want to note that we both understand all too well how hard sharing personal biographies—especially deeply emotional ones—can be in the classroom. We further recognize that existing structural inequalities often limit the ability of teachers and students to share emotional stories. In fact, marginalized instructors may reasonably fear institutional punishment for doing so, and instructors from more privileged backgrounds may reasonably fear negative student reactions to the advantages in their lives. Rather than seeking to evaluate emotional or rational techniques or suggest these techniques are somehow mutually exclusive (for the interrelation of such techniques in research and teaching, see Kleinman and Copp 1993), we thus share our biographic incorporation techniques in hopes of opening a space for discussion about the use of instructor biographies, personal experience, and emotion in sociological instruction (see also Greenfield 2006).

PRACTICAL CONSIDERATIONS OF PERSONALIZING TEACHING

In order to fully consider the potential usefulness of personalizing sociology, it is important to note that we take specific steps to organize our classrooms as "safe spaces" (see hooks 1994) for disclosure and discussion. While others have noted the potential for students to react to personal elements of their professors in hostile or other problematic ways (see Adams 2010), we have yet to have these experiences ourselves. We would thus suggest, echoing others (Adams 2010; hooks 1994), that

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setting the stage for personal disclosure and discussion may be at least as important as any biographical aspects professors or students share in relation to course materials. While the potential of negative student reactions will always be present in classrooms regardless of selected pedagogy (especially in the case of minority instructors), our experiences suggest strategically planning the ways one uses personal information and organizes the overall course may help forestall negative reactions.

To this end, we organize the entirety of our courses around personalized aspects of health and medicine and build reading, writing, and other assignments in relation to personal and emotional narratives we intend to share in class. Rather than an occasional aspect of a lesson plan, we thus make sharing personal and emotional stories a central element of the course itself, which (as students have noted in evaluations) allows students to learn to expect this as part of their education over the course of the class. If, for example, we are covering drug addiction on a given day, then the first author may open with experience helping others manage narcotics or the second author may open with stories from when he was a regular drug user. We then provide students the opportunity—via writing, open discussion, or both—to comment on this example utilizing concepts previously covered in class and then direct them to discuss some ways the story relates to the day's reading or other materials on drug use. In this way, we integrate personal disclosure into the fabric of the course from start to finish.

As the previous paragraph suggests, we thus begin each course with personal stories. On the first day of class, as noted previously, we explain the personal experiences that led us to study and teach medical sociology. Further, we take time in this first class meeting to ask the students why they are in the class and make sure to do this type of conversational sharing in every single class meeting throughout the semester. In so doing, we define storytelling and personalized conversations as common and expected elements—or rituals (see Goffman 1959)—of the course from its inception and maintain this practice throughout its completion. In the same way people learn other conversational patterns, our students thus become accustomed to personalized conversations with each repeated example of this practice as the semester progresses. Not surprisingly, students began to expect this "interactional ritual" and contribute more and more of their own thoughts to it as time goes by. This process thus "normalizes" personalization within the context of our classrooms and becomes part of the expected educational experience for our students.

While organizing our courses around conversations and sharing personal stories in every classroom set the stage for personalized and emotional teaching techniques, our evaluations have revealed another important component in creating a "safe space" for personalizing sociology—consent. Rather than requiring students to share anything personal about themselves or their lives, we introduce personal stories (from day one and repeated throughout the course) as our way of sharing with them and make sure they are aware of multiple ways they can gain full course credit whether or not they ever share anything personal (i.e., each writing assignment gives them the option of applying concepts to their lives, the stories we have shared, and/or the course materials only). As a result, students never have to share anything personal but may use our own shared experiences for the purposes of the course. In fact, students have often noted in evaluations that the fact that they did not "have to share" often made them "feel more comfortable talking about controversial or difficult topics" and "feel more appreciation for us and other students" who did "share personal experiences" in relation to course materials.

Our experiences suggest this focus on consent is especially important when utilizing emotional and personalized techniques because, as one student put it, "it allows us to be vulnerable on our own terms" as instructors and students. Put simply, anytime we (instructors and students) share emotional or personal stories, we explicitly engage with vulnerability and the practical implications (negative and positive) of the subjects we teach. In so doing, we make decisions about what we are willing to share and what we are not. Likewise, we open ourselves to potential negative reactions from others (Goffman 1959) in hopes of establishing greater engagement with materials. Rather than a necessary requirement, however, we organize the course around voluntary disclosure wherein our own vulnerability, as a student evaluation noted, "makes us feel more real, like we care" for the students while leaving them the option to speak or remain silent on any given topic that may personally resonate with their own social world.

In fact, student reactions to our course offerings on both campuses reveal the effectiveness of these attempts to date. While we can only speak to our own success utilizing the techniques suggested and questions posed throughout this article, we both generally have full rosters for Medical Sociology,

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waiting lists to get into our classes every time we teach any subject (i.e., we approach all our course offerings in a similar manner), regular requests from other departments and classes to share our approaches and insights with their students and instructors, and well above average teaching evaluations in comparison to our colleges and departments. Likewise, our efforts have been awarded and applauded in various ways to date, and we regularly meet with other instructors to provide guidance and advice. Finally, we regularly engage with students from our Medical Sociology classes long after they have taken the courses and each semester find new students in our classrooms who take our classes (whether they need them for their degrees or not) due to the praise generated by our former students.

In sum, we attempt to create a "safe space" for personalizing sociology and utilizing emotional narratives. Specifically, our experiences suggest this may be accomplished by explicitly and strategically designing courses (i.e., everything from class time to assessments to projects) around emotional and personal connections and applications to scholarship, building our biographies into every class meeting throughout the entirety of the course, and defining personal and emotional sharing on the part of students as optional and removed from any grading requirement. In fact, we would imagine conversations about the use of instructor biographies in classrooms would likely reveal other strategies for creating spaces conducive to personalizing sociology for our students. Further, it is likely that discussions about vulnerability (i.e., when and how to be vulnerable in the classroom from student or instructor perspectives) may be especially useful for instructors navigating varied institutional contexts and personal biographies. To this end, we now turn to qualitative examples of the ways we use our biographies to personalize sociology for students in hopes of generating conversations, reflection, and debate about the usefulness of biographic incorporation in sociological instruction.

PERSONALIZING STUDENT ENGAGEMENT

As suggested previously, we have regularly seen ways our personal and emotional biographies encourage students to become more active in the classroom. In some cases, such activity manifests in the form of class discussions that animate the delivery of course materials by rendering lecture techniques impossible or unnecessary due to students' desire to debate materials, concepts, and experiences in relation to both. At other times, students utilize both their own medical biographies and ours in their test answers, class projects, and articulation of concepts in class. Especially at the research-focused university, our colleagues are regularly stunned by both the comprehension of our students (in our own classes and theirs) and the level of discussion in our classrooms. In this section, we note some ways we use our biographies to encourage student engagement with specific medical topics.

One of the topics we both cover in our classes concerns the ways social factors may represent fundamental causes of health disparities (see Link and Phelan 2010). When explaining this theory to students, we each give personal examples of the way this works to allow students to recognize concrete ways social factors influence their own health. In the first author's course, for example, she notes a time when a local community outreach group was giving out free turkeys to low-income families for Thanksgiving. In this case, the outreach group members were shocked to learn that some people did not want the turkeys and others gave them away. In fact, students are often shocked by this fact as well. However, this fact makes logical sense when we realize—as the outreach group members did in time—that many low-income families do not own stoves or other necessary ingredients for cooking turkeys. As the first author explains in class, such examples reveal that even when people know about healthy food and want to develop healthier lifestyles, economic resources can prevent them from doing so.

Considering the economic backgrounds of the bulk of people who attend college in America, it is not surprising that this news shocks our students. However, their shock is not the necessary component in this lesson. Rather, students generally become very angry and passionate about food insecurity, try to imagine their own holidays without a stove, and begin attempting to figure out ways to solve this problem utilizing sociological insights. As one student suggested, "What the hell are we doing talking about individual responsibility on T.V. when that won't do these people any damn good?" In such responses, students engage with fundamental causes theory (Link and Phelan 2010) and the limits of individual answers to social problems related to health. Moreover, they come to this conclusion organically because the story forces them to reevaluate their assumptions about poor people and the origin of negative health outcomes.

We see similar dynamics in our courses when we cover experiences with health care systems. In

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his course, for example, the second author introduces this section by recounting his experience living in a hospital for a few weeks while his first love died as a result of HIV/AIDS (see Cragun et al. 2014 for a reproduction of the experience). The second author explains in detail that often leads to tears what it was like when some doctors and nurses went out of their way to find him blankets, make his friend and former boyfriend comfortable, and protect them both from harassment. The second author further explains what it felt like when other doctors and nurses tried to make him leave, told him his loved one deserved to die, and promised him he'd be laying there the same way someday. Finally, usually in tears himself, the second author finishes the story by casually noting that his first love did not get HIV/AIDS through sexual activity (as assumed by many people in the hospital while he died) but rather through a bad blood transfusion. As the second author explains in class, such examples reveal that much of health care experience has little to do with medicine.

In response, students generally offer a plethora of experiences they or their friends and family have had with health care. The second author then guides them to explain the ways social factors facilitated both their negative and positive experiences with health care, and they begin to ask about potential social factors that could have influenced their experiences without their knowledge. Further, students quickly connect the dots by saying things like, "if that was my boyfriend," "what if that happened to my mom," or "how could anyone think you would leave him to die." In such responses, students begin to actively consider the social influences on health experience as well as the ways oppression and privilege manifest in various social contexts and settings. Once again, however, they come to these realizations before they read scientific studies on health care experience and thus may use their emotional reactions to make sense of, talk about, and interpret such studies.

While we could provide a litany of similar examples, the take-home point remains the same—students' reactions to biographical experiences can motivate them to personalize medical theory and research as well as become engaged in the classroom as active participants. Similar to the ways service learning techniques have been shown to engage students by revealing unpleasant realities scientists grapple with daily (Lichtenstein and DeCoster 2014), personal stories can put a face on social patterns of disparity and reveal the importance of scientific research in the real world. Unlike service learning techniques, however, teachers may utilize their biographies even when their schools do not support or encourage active learning in financial or other ways. While we would suggest optimal instruction techniques would include both stories about and experiences of the world, stories may be especially useful in settings where service and other types of real world learning are not feasible.

We thus share these engagement techniques to encourage sociologists to consider ways personal biographies could be useful within their own course offerings. While we have experienced only positive effects from such efforts, we also ask others to consider the limitations of this approach as well as ways this approach can be integrated with more traditional methods instruction-like lectures. As captured in the previous qualitative examples, personalizing scholarship can influence engagement with social patterns and systemic issues. As such, discussions about such efforts might provide useful ground for sociologists establishing and outlining teaching techniques concerning various social issues and problems.

PERSONALIZING CRITICAL AWARENESS

Like many topics within sociological teaching (Lucal 2015), Medical Sociology courses often wrestle with systemic patterns of interpersonal and structural inequality (see Lichtenstein and DeCoster 2014; Rondini 2015). In fact, due to the necessity of incorporating biological, psychological, and sociological science into our courses, medical sociologists typically have to figure out ways to maintain awareness of inequalities in many course materials that do not address this aspect of health. To this end, we share our own experiences with interpersonal and structural patterns of inequality and emphasize the socially constructed basis of all medical knowledge and practice. In so doing, we seek to help students develop critical perspectives necessary for ascertaining the value of different types of information, perspectives in the world, and experiences with health (see also Grollman 2012).

On an interpersonal level, we often use our biographical experiences with health care to reveal the ever-changing and socially constructed nature of medicine across the world and in different time periods. Exploring processes of diagnosis, for example, the first author recounts experiences with the chronic condition that almost ended her life:

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> Although I had access to quality medical care and experienced incredible pain for years, I finally received a complete diagnosis of non-specific mucositis at the age of 24. This condition is idiopathic, meaning that its origins and mechanisms are not fully known by medical professionals. It is also intractable—I can control the symptoms to some extent, but I cannot eliminate it. I also cannot reverse the damage done before I had a diagnosis.

Rather than an objective scientific procedure, the first author thus uses her own experience to reveal the limits of diagnostic categories for understanding human beings as well as the ever-evolving nature of medicine and the importance of continued funding for medical research, testing, and access for all people (see also Mirowsky and Ross 1989). In so doing, she encourages students to think critically about the medical knowledge or access we may "take for granted" and ask where these ideas and patterns come from and how they might change in time.

At other times, we utilize our biographies to outline the ways structural inequalities impact health management and decision making. When discussing cosmetic surgeries—such as breast enhancements, nose jobs, and liposuction—in his class, for example, the second author outlines just how easy it is to get these procedures if one has money. After showing students how happy doctors are to provide these services to men and women and the limited diagnostic or medical testing such procedures require, the second author asks the following questions: "If these things are, as the doctor just said, no big deal, why do you think I was required to go to counseling for a year before I could see anyone about getting breasts? Why would I need therapy to get breasts when the woman on the video simply needed an appointment and a checkbook?" In so doing, the second author uses his own experience considering biological transition to introduce students to the ways existing gender norms and assumptions influence medical practice (see also Schilt 2010). Further, the second author uses this experience to encourage students to discuss why a "condition" that only requires "cosmetic" surgery would be classified as a medical disorder in the first place. Rather than preexisting or natural standards, students thus debate medical definitions and protocols as socially constructed patterns of action and in so doing, consider that such patterns, like other social patterns, may ultimately be changed at any time to better serve the public.

Although we could once again offer a multitude of examples, all such cases echo the aforementioned by demonstrating the ways biographical stories can help students see the actual human cost of medical limitations, inequalities, and patterns of action. Whether the first author is explaining to students what it feels like to be ignored by her doctors even when she has as much or more medical training as they do or the second author is explaining what it was like to exist with chronic mental and physical health conditions for years without health insurance, the use of personal stories can put a face on health care debates concerning access, research, and protocols taking place throughout American society. In so doing, such personalized cases can provide the emotional commitment necessary for developing and acting upon critical awareness about societal patterns of health disparity (see Rondini 2015 for similar uses of service learning).

As a result, our experiences (personally and in classrooms) suggest that considering the ways we can put a "face" on systemic social problems may be useful in many subject areas. We would thus encourage other sociologists to consider ways of personalizing awareness of social problems for students and guiding students through debates about these issues in relation to concrete examples. Further, we would suggest that personalizing awareness within classrooms could (as it has in our own classrooms) open up possibilities to teaching students ways to apply sociological concepts and methods to many concrete experiences in their own lives.

GENERALIZING MEDICAL EXPERIENCES

While our use of emotional narratives can personalize engagement and critical awareness, it also allows us to implicitly generalize medical experience. Similar to other stigmatized identities that are often invisible to the casual observer (see Adams 2010), many people walk through their daily lives managing serious health conditions without the knowledge of others. In so doing, however, they can often develop the impression that they are alone in their struggles (see Sumerau, Schrock, and Reese 2013 for similar experiences with other invisible identities). At the same time, people may experience a social reality where they lack knowledge of the many people managing serious health conditions all around them. By sharing our biographies in classrooms, we are able, like many other teachers with stigmatized identities, to *both* direct

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students' attention to the existence of people managing serious health issues in their midst *and* provide space for others with serious health conditions to recognize they are not alone.

To make sense of these dynamics, we borrow the notion of "coming out" from research, teaching, and activism by and for sexual minorities (see Adams 2010). In so doing, however, we do not suggest that managing health conditions represents the same experience as managing sexual discrimination or other forms of discrimination that lead people to feel the need to hide aspects of their selfhood (see McLean 2007). Rather, we use this language to highlight the often invisible character of chronic and other serious medical conditions and the potential of providing forums and opportunities for medical disclosure, social support, and social justice for those living with ongoing or acute health conditions that radically alter their lives. In much the same way racial, class, gender, and sexual minorities are confronted continuously with social norms that privilege white, upper-class, cisgender male, and heterosexual perspectives, people managing health conditions often experience the world confronted by the ongoing elevation of ablest assumptions constructed at their expense (see Cahill and Eggleston 1994).

As we have learned from other subordinated communities and experiences over time (Lucal 2015), classrooms can be a place where ablest assumptions are put aside and the diversity of human bodies, health statuses, and functional abilities can be embraced and affirmed. Our experiences—individually and collectively—have taught us that sharing our own medical biographies can accomplish such goals. The second author, for example, has regularly witnessed students—in class and in office hours—using his own disclosures in terms of sexualities, gender, and health as springboards for sharing their own management of conditions including but not limited to Crohn's disease, sickle cell anemia, type II diabetes, auto-immune disorders, physical and emotional sexual dysfunction, bipolar disorders, ADHD, traumatic injuries (e.g., car accidents, sports injuries, and military-related traumas), and sexually transmitted infections. Further, in many cases, students have not sought help or support concerning these conditions due to shame, fear, or silence surrounding these issues and were thus—through the course—able to make better health decisions for themselves, locate understanding and qualified health providers, and realize there was nothing to be ashamed of in the first place.

In a similar fashion, the first author regularly discussed her own medical experiences in relation to her professional connections with medical schools, clinics, and practitioners in her area. In so doing, she has often accomplished similar results and been able to utilize her own medical expertise to educate and encourage students in need of support and guidance. In the process, her own disclosures have facilitated student articulations of and discussions about conditions including but not limited to PTSD, gallstones, rhabdomyolysis, dementia, heart disease, hepatitis, candidiasis, amputation, lupus, pregnancy, pre-eclampsia, bariatric surgery, depression, and cancers of varied sorts. Further, these disclosures have allowed her to become an instrumental and emotional resource for students dealing with such issues themselves or within their families and networks. Rather than limited to course work, such guidance allows students to gain information and support capable of impacting their overall lives.

Expanding beyond health conditions, our efforts also often create a classroom space that (as students regularly tell us personally and on evaluations) encourages sharing other aspects of their lives that have ramifications for overall health. Since both authors disclose both experiences with abuse and health effects tied to abuse and discrimination as part of their courses, students often come forward seeking guidance, understanding, or simply a supportive ear while dealing with, for example, sexual and gender identity issues, intimate partner violence, intimate partner selection practices, substance abuse and use, abuse (sexual, physical, and/or emotional) experiences in childhood or adulthood, and dealing with the aforementioned social issues in health career fields and settings. Considering the silence often surrounding such concerns and realities within our current social structure (see De Welde et al. 2014), our incorporation of biographical experiences creates a space where students are able to talk to instructors and other students about these concerns and gain access to potential guidance that may not be found in other aspects of their life. Further, other students witness the social nature of these issues and concerns and in so doing, may begin to see them as general concerns in need of social action rather than isolated incidents.

Our use of personal and emotional biographies thus creates a classroom space where students feel comfortable sharing their own experiences and issues and seeking help and guidance that can extend beyond their educational and occupational endeavors. Similar to the ways reflective journaling and blogging can

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facilitate student connectivity with course material (Foster 2015), incorporating instructor biographies can provide an opportunity for students to approach their own issues in shared and individualized educational settings. In fact, we have both regularly included journaling and/or personal reflection assignments in our courses, which students have used to further elaborate the ways their own lives relate to course materials. We thus argue that our experiences could provide an avenue for sociological conversations about the potential (and the limitations) of biographic incorporation in classroom settings.

CONSIDERATIONS OF DISADVANTAGE AND PRIVILEGE IN INSTRUCTOR BIOGRAPHIES

Our experiences delivering Medical Sociology in two separate university cultures to date have revealed potential benefits of incorporating instructor biographies into sociological curriculum. In fact, our experiences thus far suggest providing abstract, statistical, and other data-driven fields with concrete faces and biographies may facilitate high levels of engagement, critical awareness, and generalized recognition of the impact of social structures among our students. Whether used independently or in relation to other techniques, our experiences suggest it may be important to discuss the benefits and limitations of incorporating instructor biographies into existing sociological curriculums and pedagogical approaches.

To facilitate such debate, however, it is important to consider the differential social locations of instructors themselves. In the case of minority scholars, for example, incorporating elements of personal biography may—as we have experienced—be met with positive reactions due to students' newfound ability to recognize social patterns in the case of a concrete person they interact with over the course of a semester. On the other hand, minority scholars may reasonably fear reprisal from students and administrators when elements of their biographies reveal uncomfortable social realities or marginalized standpoints. Sociologists should thus consider what structural and biographical contexts better facilitate biographical incorporation and what barriers or concerns may forestall such incorporation. Further, it may be useful to discuss and investigate what factors may lead minority instructors to embrace or oppose biographical incorporation in their own courses. Finally, sociologists might address the ways such inclinations vary in relation to varied race, class, gender, sexual, bodied, religious, or national social locations instructors occupy on a daily basis both personally and professionally.

By the same token, the experiences of instructors occupying privileged social locations reveal further topics to consider. When one has experienced a rather privileged biographical reality, for example, how might they engage such experience with students in ways that draw attention to privileged social locations without triggering negative reactions from students who occupy less privileged positions and/or do not wish to think about their own privileged location? Likewise, sociologists should discuss the potential difficulties instructors from more privileged backgrounds may face in seeking to translate their biographies into sociological understanding of the variety of individual and structural experience. If, for example, their stories have more to do with pleasure than pain as a result of existing social structures, then what techniques might they develop to use such biographical content to alert students to the marginalization of others? Finally, instructors occupying more privileged social locations—like other members of society (Collins 2005)—may experience considerable discomfort when explicitly noting their privilege in the classroom, which may necessitate thinking about ways to support such effort.

These questions about social location also reveal the importance of debating benefits and limitations of biographical incorporation in the classroom. In the case of minority instructors, for example, they may be able to personalize unequal social patterns in society for students, but doing so may also involve risking sanction or further marginalization depending on the level of institutional support they receive from departments and colleges. Likewise, instructors from more privileged backgrounds may be able to de-naturalize unequal social patterns by explicitly noting their own privileges in the classroom. However, doing so may increase risk incurring sanction (especially from students) or result in uncomfortable and unusual experiences of vulnerability because of the sacrifice of privacy that is commonly afforded by positions of privilege. The complexities instructors may face when seeking to incorporate biographical elements into their courses from marginalized or privileged perspectives thus suggest ample ground for discussion and debate about the usefulness and danger of adopting such pedagogical techniques for instructors working within and experiencing varied institutional and structural contexts.

These questions also reveal the importance of discussing the ways we go about incorporating

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biographical elements into existing course offerings. In the case of minority scholars, for example, existing structures already require discussing the experiences of more privileged groups and individuals in relation to minority experiences, and our social world provides many examples for use (Collins 2005). Scholars may simply use their own biographies to compare and contrast marginalized experience with dominant assumptions. Further, such scholars often find plenty of useful biographical accounts of privileged people in mainstream media and arts. They may (as we have in our courses) biographically represent distinctions in the biographies of dominant and subordinate groups for their students.

In the case of scholars from more privileged backgrounds, however, incorporating biography may be more complicated because their biography will more likely speak to dominant assumptions and examples (personalized and group based in both media and scholarship), which will necessitate gathering marginalized experience from another source for comparison and contrast. While such instructors could go about this process in many ways (including but not limited to the use of autobiographies from people in marginalized groups or using stories shared by minority scholars on academic platforms like www.conditionallyaccepted.com or www.writewhereithurts.net), any method adopted will require figuring out ways to integrate privileged and marginalized biographical experience in the classroom. As such, scholars who decide to incorporate biographical elements into their courses will need to discuss and consider methods for doing so that speak to the complexities of the contemporary social world.

Finally, the incorporation of instructor biographies into sociology courses will necessitate discussion about vulnerability. While our own experiences offer two cases where embracing vulnerability in the classroom produce positive educational experiences, it is equally possible, as noted previously, that instructors may face a wide variety of reactions to such efforts. As a result, we suggest that it may be wise to begin discussing the benefits and limitations of incorporating instructor biographies in the classroom (see also Adams 2010; hooks 1994) in order to ascertain the ways such efforts may enhance sociological instruction as well as the variations in instructors' personal and structural realities that facilitate adoption of biographical incorporation for some and opposition to this possibility for others. In so doing, we may generate a conversation capable of providing guidance for future sociologists seeking to develop the most effective teaching strategies for their careers, their students, and sociology as a whole.

CONCLUSION

Throughout this article, we have used our own experiences teaching medical sociology classes to call for discussion concerning the benefits and limitations of incorporating instructor biographies into sociology courses. In so doing, we have shared the ways such incorporation facilitates student engagement, critical awareness, and medical coming out processes. Considering the popularity of our courses, our experiences suggest that the incorporation of instructor biographies could be beneficial to sociologists in many ways. However, adopting our approaches on a wider scale will necessitate making sense of variance in instructor biographies and institutional contexts and engaging in serious debates about the merits, barriers, and other nuances individual instructors may face in their teaching endeavors.

To this end, we conclude by calling for conversation and consideration of the incorporation of instructor biographies into sociological education. While our experience has been very positive in this regard, we cannot pretend that others may face issues we have not and that others still may oppose this method for reasons of their own. As a result, our experience leads us to think open dialogue about this issue might be beneficial to all sociology instructors regardless of the instructional methods they select. It is with an eye toward the ongoing development of teaching practices that will most effectively benefit instructors and students that we thus ask our sociology colleagues to consider whether or not they think we should talk about the pain in our classrooms.

EDITOR'S NOTE

Reviewers for this manuscript were, in alphabetical order, Joslyn Brenton and Trina Smith.

AUTHORS' NOTE

Although both authors identify as genderqueer and generally favor gender-fluid self-presentations and gender-neutral language, we utilize gendered pronouns throughout this piece to capture the way we may appear to our students in the classroom. In such settings, the first author generally dresses in ways typically interpreted as feminine while the second author generally dresses in ways typically interpreted as masculine. We thus use gendered language to both capture the ways our students may initially interpret us and note similarities in our experience even when interpreted as differently gendered beings by students.

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AUTHOR BIOGRAPHIES

Alexandra C. H. Nowakowski is research faculty at the Florida State University College of Medicine and adjunct faculty in sociology. Dr. Nowakowski's teaching and research focus on experience and management of chronic conditions, social causes of and responses to health inequalities, and evaluation of programs and services that promote health equity. Lifelong chronic illness and a passion for social justice motivate Dr. Nowakowski in advocating for others with health challenges through a variety of professional service activities.

J. E. Sumerau is an assistant professor of sociology and director of the applied sociology program at the University of Tampa. Dr. Sumerau's teaching and research focus on the intersection of sexualities, gender, religion, and health in the historical and interactional experiences of sexual, gender, and religious minorities.

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