Dr. Darcy L. Harris

Most of my training in health care was focused on the patient as an individual. We were taught about the specifics of physical health and illness in the form of an assessment of the patients’ symptoms, including their subjective descriptions of pain and stress. In some venues, mostly hospice/palliative care settings, the unit of care extended to the patient’s family. For the most part, however, the focus remained on individualized accounts of symptomatology and determining the appropriate diagnostic category followed by a decision regarding the appropriate technical/medical intervention, and then evaluating the outcome using the reports of physical indicators and subjective responses of individual patients. The assessment form we used at that time included specific bodily systems for us to document in our initial patient interview. At the bottom of the form, almost like an afterthought, a small space was allotted for “psychosocial concerns.” We listened compassionately and supported the patient and family members’ expressions of angst and anxiety as they related to the illness of the patient. We felt good about the care that we offered, and we did care deeply about our patients and their families. However, we rarely explored or even considered the social context of our patients and how their individual experiences were shaped and molded by forces other than just the disease process at hand.

My graduate training program in counseling psychology included an introduction to critical theory and feminist therapy. During my time in this program, I began to piece together an appreciation of the social forces and institutions that are deeply embedded into almost every aspect of an individual’s experience. I knew that access to resources was a key issue for those who did not have adequate insurance or funds to cover their care, but up to that point, I had very limited awareness of how class, race, culture, and gender profoundly affect individual experiences. I also had never considered the impact that historical discrimination and oppression might have on the interactions that occurred in my present day world.

The experiences of loss, death, and grief may be universal, but each person’s unique perceptions, choices, perspective, and interpretation of meaning are shaped and molded by many socially-mediated factors. A person’s idea of what quality of life means will be profoundly influenced by his or her culture, race, gender, and class. For example, if a person with a terminal illness has spent a lifetime being rewarded financially and socially for being highly independent, suffering an illness where there is dependence and debility may have a very different meaning than for someone whose identity has been formed around mutual caregiving and kinship relationships, where interdependence within the community is viewed as normal. Historical contexts also come into play as well. While...
the current generation of young people in the United States may have many role models that have
crossed previous barriers related to race, class, and gender, they have grown up in homes where
their parents most likely were affected first hand by civil rights marches, bigotry, discrimination
due to race and/or gender, and the feelings that stem from these experiences. The painful memories
and associated feelings do not necessarily change because of rhetoric about equality and desegregation
in the present day. Below are some examples of how social issues may be relevant to death, loss,
and grief:

• Most service sector work is performed by women and is still viewed as “women’s work,” with
  lower compensation than in other sectors. In health care, nurses and social workers are now
tasked with increasingly larger patient loads and more complex care patients while they also
hit against caps on their income and stagnant salaries that don’t reflect their essential role in
patient care (Rajapaksa & Rothstein, 2009; Reineck & Furino, 2009).

• Allopathic medicine is the dominant model of medicine in Western industrialized countries;
  other types of medicine (i.e., traditional Chinese medicine, ayurvedic medicine, homeopathic
  medicine, Native American medicine, and naturopathy) are devalued as “non-scientific,”
  practiced by charlatans and “quacks.” However, individuals who use both allopathic and
  alternative types of medicine together may, at times, have better outcomes than those who
  access allopathic medical care alone (Baer, 1989; Caspi, Koithan, & Criddle, 2004).

• There is a bias toward funding research and innovation in areas related to the surgical supply
  industry and pharmacologic development for new (and potentially profitable) pharmaceutical
  agents (Rothman et al., 2009). Hospice and palliative care as specialties are devalued due to
  the tendency to view death as failure in the current medical milieu and the fact that most of
  the equipment and pharmacology associated with terminal care is already out of patent and
  thus not as lucrative to potential funders.

• There is often a negative association of counseling and therapy with weakness and dependence.
  Many insurance companies will either not cover expenses related to counseling, or will do so
  only minimally. However, it is known that individuals who experience complicated grief after
  a significant loss can benefit from well-timed professional intervention (Shear, Ghesquiere, &
  Glickman, 2013).

• Individuals with higher incomes have greater access to various care options and choices
  through their insurance coverage or by social preference due to their status. Individuals at the
  bottom of society have shorter lives and suffer more illness (Ballatt & Campling, 2011).

• Experiences that involve emotion are devalued; grief and chronic sorrow are only allowed to
  be expressed and socially supported under certain conditions, for a limited period of time, and
  in socially acceptable ways (Doka, 1989; Harris, 2009–2010).

Consider the following examples:

Janet was a 43 year-old mother of two young children. She was also a massage therapist and
reiki practitioner whose office was in a complementary therapy co-operative. She was diagnosed
with breast cancer and underwent a lumpectomy. Her oncologist recommended a regimen of
chemotherapy after her surgery. However, Janet said that she “didn’t want to pump chemicals”
into her body and declined this treatment, opting for alternative medicine and meditation instead.
Two years later, Janet was found to have metastatic cancer in her bones and brain. When Janet
presented to the oncology clinic at this time for re-evaluation, one of the nurses remarked (out
loud where Janet could hear) that “if she had made the responsible choice, her two children wouldn’t
be facing the loss of their mother.” When Janet died, her two children created a mandala together
that was placed on her casket at the funeral service.
Janet was a competent adult who did not align herself with the predominant views of allopathic medical care. If you were a health care provider in this situation, what would your feelings be? Why do you think the nurse made the negative comment about Janet?

Amy was a nursing student who lived in the dorm at the university. She would often go to the library to study in the evenings because it was quiet. She had studied hard all evening for an exam that was scheduled early the next morning. At one a.m., Amy was awakened by loud talking, laughing, and music coming from the room across the hall from her. At two a.m., the music and loud talking continued and she was worried that she would not be able to do well on her exam due to lack of sleep. She got up, put on her bathrobe, and knocked on the door where the music was being played. Two young black women answered the door. When Amy told them she needed to sleep and their music and conversation were keeping her awake, one of the young women angrily replied that Amy was a “little rich white girl who needs her beauty sleep,” and slammed the door on her. Amy was shocked. She had never spoken ill to these girls before and she had always been taught to be respectful to others. Amy was neither rich nor did she have time to worry about her appearance because she was spending all of her time studying and working at a job to get through school.

Amy had never shown any disrespect or negativity to the two young women who lived across the hall from her. Why do you think they responded to her the way that they did? What assumptions do you think they were making about Amy and what might have informed their assumptions? What historical factors may be influencing the responses of the girls and Amy?

Alma was a 63 year-old black woman who was admitted to the intensive care unit after suffering a stroke at home. Alma was unresponsive and on life support. The doctors (both were male; one was white, and the other Asian in appearance) spoke with her family, telling them that the stroke was massive and that Alma would never be able to breathe on her own or respond to them again. The doctors requested permission to move Alma from life support because her brain was showing no electrical activity and she was essentially brain dead, with the life support machines keeping her body functioning. The family refused, stating that they wanted everything to be done for Alma, including remaining on the ventilator and being fed intravenously. The doctors left the family and went into the unit. The doctors and nurses then talked among themselves about how unreasonable this family was and that they wouldn’t listen to “common sense.”

Alma’s family all heard the doctors tell them that she was brain dead. Why do you think the family chose differently from what the medical providers were recommending? What do you think the doctors and nurses in the unit were feeling toward Alma’s family? What might be the implications to the family for not agreeing to the recommendations of the doctors?

Social and Political Underpinnings and Power

When we begin to explore social and political influences, we are essentially talking about how power is distributed within a society. Power in this context can be defined as the ability to have influence, control, superiority, or an advantage over others (Brown, 1994). It is important to see that systemic power relations exist between social groups that are identified in a society. Being ascribed power also means that you have more freedom to choose and more options available to you than someone who is not seen as socially powerful. Individuals or groups who have more social power can afford to be oblivious to other groups’ needs or opinions. Power may have a negative connotation, such as “power over” another person or “domination” of the environment. However, it may have a positive side, such as when a person or a group is “empowered” in a way that frees them from oppression, whether the source is internal or external. In the social context, people who are powerful are those who are able to determine the norms for all social groups within their sphere. All interactions between individuals and groups will have a power dynamic at play, whether that dynamic is obvious or not.
If you stop and think about whose opinion matters and what types of people are set up as examples of success, you might identify high-ranking political figures, sports heroes, and movie stars. You might also think of people who have made breakthroughs in medical science or in information technology. Most of these individuals have high incomes, very comfortable or perhaps even lavish lifestyles, expensive clothing, a certain type of appearance that usually sets a trend for others, and/or a significant sense of being very special as a result of their unique accomplishments or public persona. Because of their status, you will often find these individuals being granted credibility in many topics that are completely unrelated to their area of expertise. Sports stars make highly publicized comments on religious teachings and beliefs. Surgeons may provide opinions on public education policy. Movie stars often use their celebrity status to promote products, causes, and political nominees for office. The reason these individuals are given such broad credibility has to do with the fact that they possess social power by virtue of their perceived success and celebrity status.

We are all born into social groups, and these groups pre-exist before us as social structures. The social and political significance of these groups is established and maintained socially (i.e., not by nature or by divine intervention). Group identities are socially elevated or diminished in relation to one another, establishing structural power relationships between these groups. Individuals are oppressed or privileged by virtue of their membership in various social groups, which may be delineated by race, class, gender, religion, culture, or some other category, such as the type of work performed (i.e., “blue collar” versus “white collar” workers). Membership in groups as a result of certain experiences may also lead to oppression or privilege, depending upon the group and the experience. For instance, individuals who win a large amount of money through a lottery may find a great deal of social power and influence that is usually associated with the dominant group that was not theirs prior to the experience of winning the lottery.

Through our early attachments, we learn about how we are valued socially and our “position” in society relative to other individuals and groups. Our assumptive world becomes formed around our attachment system, and this assumptive world provides us with explanations about how the world works, the expectations we have in our interactions with others, and our view of ourselves in relation to others (Harris, 2011; Janoff-Bulman, 1992). Our family system is the first experience of the world beyond ourselves. From our family system, we learn about how to treat others, what is “right” versus “wrong,” and what is valued and what is devalued. Our family system may also introduce us to formal or informal religious teaching, which would further delineate a code of values and world view that was most likely implicit in our early years. We then enter into the formal educational system and learn the values that are espoused and socially reinforced there. The school system exists within the larger socio-political system, which determines the content of educational curricula and the amount and designation of funding that is applied to the various educational institutions and programs. At any time along the way, we most likely will have interactions with other social/political structures, such as the health care system and the laws and public policies that have an impact upon our choices and access to resources. We learn to whom we should defer and who defers to us socially. Our history becomes embedded into our identification with our kinship culture and racial groups, typically along gender-identified roles, and is stratified by income, level of influence, and perceived position in relation to others.

After reading this section, go back to the three scenarios we just discussed in the last section with Janet, Amy, and Alma. Think of how the power dynamics in these situations might be playing a role in what has happened. Who in the situation is viewed to have power? What are the responses of individuals who are less powerful because of identification with a non-dominant group, racial discrimination, or lower class? What are the responses of the individuals who are identified with a group that has power or is part of the dominant group? What historical power dynamics might be informing these scenarios? In doing this exercise, you are beginning to think critically about situations, and learning to think and reflect in this way is essential if you wish to become informed, compassionate, and effective in diverse settings.
The Development of Critical Consciousness

Kumagai and Lypson (2009) describe the need to move the delivery of health care beyond the technical components that focus mostly upon laboratory data, differential diagnoses, and treatment options for disease entities to the development of what they term critical consciousness. This type of critical inquiry takes into account that individuals do not exist in isolation, but instead, all individuals exist in relationship to others in the world. Critical consciousness involves a reflective awareness of the differences in power and privilege and the inequities that are embedded in social relationships—an act that Freire calls “reading the world”—and fostering of a reorientation of perspective toward a commitment to social justice. The development of this type of consciousness—a process that Freire calls “conscientization”—is both cognitive and affective and leads to engaged discourse, collaborative problem-solving, and a “rehumanization” of human relationships.

(Kumagai & Lypson, 2009, p. 783)

The development of a critical consciousness includes not just acquiring knowledge about physical illness and its treatment, or even about the normal course of grief as described by bereavement researchers and theorists. In order to cultivate this type of awareness, the practitioner must be willing to first engage in critical self-reflection, where there is a pause to understand one’s core assumptions, biases, and values, and be able to shift that gaze from oneself to others and to the conditions of injustice in our world. Thus, it is imperative that practitioners become aware of how their beliefs and assumptions have been formed, and how these views may have an impact upon their interactions with others. In addition, there also needs to be an understanding of social issues (both relational and systemic) in order to engage in reflective, ethical practice.

Let’s look at another case example: Joe was a 66-year-old black man who was diagnosed with metastatic cancer. Joe lived with his wife Ann in a subsidized housing complex. Ann took care of their two grandchildren during the day while their daughter worked. She also looked after two of her neighbor’s children during the day for extra income. Joe had developed symptoms two years before his diagnosis. However, he did not seek medical care because they had no medical insurance, and he was concerned about the expense of going to the doctor. His diagnosis came after he collapsed and was taken to the emergency department by a neighbor (they did not have a car and Ann could not leave the children in her care to go with him). After admission to the emergency room, tests were run and Joe was told there was “cancer in many places in his body.” He was given an appointment to see an oncologist, who referred Joe to the local hospice.

Joe and Ann were devastated by the news. However, they also felt a sense of relief that the government had something called a “hospice benefit” that would cover all the costs of medications, equipment, and the visits from the nurses and hospice team. Unfortunately, the hospice care in their area was strictly home care, as there was no residential hospice or palliative care unit in their community. This presented difficulties for Ann, who could not care for Joe at home in addition to their grandchildren and the other children who provided her with an important source of income for their household. She knew their daughter would not be able to afford childcare for the two grandchildren that Ann watched for her every day while she worked. Even though the hospice nurses were helpful and responsive, neither Joe nor Ann felt completely comfortable being at home alone as his condition worsened, but they could not afford (nor were they offered) other options.

Looking superficially at this scenario, many people would feel that Joe is fortunate that there is a hospice benefit available to cover his expenses. He now has access to care without the added burden of trying to find a way to pay for it. However, in agreeing to accept this benefit, he and Ann are faced with other issues that the benefit does not address, such as being forced to stay home.
where they feel isolated. In addition, if Joe stays in the home and Ann becomes the primary caregiver, her source of income and her daughter’s work could be placed at risk because she would not be able to be Joe’s primary care provider and adequately supervise the children in her care. They do not have other viable options available for Joe’s care because they do not have the income or insurance to pay for it. They have not chosen hospice care for its merits; rather, it is a forced choice based upon financial expedience and not upon an understanding or embracing of the hospice philosophy of care for them.

Issues of class, race, and income are all embedded into this scenario. It is unlikely that the hospice nurses and other team members realize that Joe and Ann have signed the hospice papers out of necessity and not out of free choice, and even if they did recognize this fact, they might even assume that they would provide Joe with the best care because of their own belief in the hospice philosophy, indicating that they believe that they know what is best for Joe and Ann.

As you consider this scenario, think about the following:

1. How is social power manifest in this situation?
2. How were Joe and Ann’s choices affected by their social status? What were the determinants of their social status?
3. If Joe were a business executive with a high income, how would his situation differ from the Joe that is described here?
4. What is the responsibility of the hospice workers to ensure that Joe and Ann have been able to freely choose the hospice program for Joe’s care?
5. How are the hospice care workers limited in their care delivery in this scenario?
6. Why might the hospice care workers feel that they know what is best for Joe and Ann?

As stated previously, most health care professionals would be focused on treating Joe’s symptoms and ensuring he had adequate control over the pain related to his cancer. This focus is probably shared by Joe and Ann as well. However, the concept of total pain, as identified by Dame Cicely Saunders in her approach to hospice palliative care, refers to the multidimensional nature of pain to include not just the physical, but also the psychological, social, and spiritual domains that are part of the experience of pain (Mehta & Chan, 2008). In this instance, while Joe may be assured of the relief of physical symptoms related to his advancing cancer, there is no addressing the anxiety and angst that are caused by the requisite home care and their feelings of isolation, let alone the concerns regarding the loss of their only remaining source of income through Ann’s home daycare.

Ways of Knowing

An important aspect of critical inquiry is to ascertain what kinds of knowledge and information are valued and what is then devalued because it veers away from the socially accepted norm. For instance, most Western industrialized societies place a high value on objectivity, positivism, stoicism, and intellect. People in Western society shy away from knowledge they cannot verify, which leads to exclusionary thinking and privilege toward linear thinking. Professionals whose training has involved higher education and learning focused on the cultivation of intellect typically have higher incomes than those who do not have this level of education. The scientific method is seen as the standard to which all other types of learning and knowing are compared. Individuals who show more emotion, who don’t formulate their knowledge by the scientific method, or who do not excel in typical academic pursuits have less social power than those who do. This creates a class system of intellectual privilege and power in relation to other types of knowledge and learning. And yet, intellectual learning alone has limitations when that learning is applied to human interactions. We can all think
of individuals who are intellectually very bright, but who do not know how to engage with others in a healthy or meaningful way. Many individuals are admitted into medical school and higher education programs simply on the merits of their academic marks, which are a reflection of intellect, without any consideration of the attributes and relational skills of the person who has earned this academic achievement. The sad result is that we often have medical doctors and educators who are gifted intellectually, but are not able to relate to their patients, students, or others in a humane, compassionate way.

It is important to recognize that Western societies’ privileging of intellectual knowing supersedes all other forms of knowing, such as intuitive knowing, common sense knowing, affective knowing (sometimes referred to as emotional intelligence), spiritual knowing, perceptual knowing, and imaginal knowing (Hassel, 2004). Individuals whose primary way of knowing is not intellectual knowing are often considered to not be very smart—or even worse, seen as backward and primitive. In the earlier scenario with Janet, who chose not to accept allopathic medicine (which is based on the scientific method), the nurse makes a derogatory comment about her choice, stating she has been “irresponsible” not to avail herself of the what she views as the “right” choice for Janet. Perhaps not taking in “chemicals” is more important to Janet than the potential to prolong her life. Perhaps this choice was Janet’s way of feeling that she is able to make her own choices instead of having them dictated to her. Maybe she wants her children to see her as a role model for thinking independently. Another possibility might be that spiritual knowing was more important to Janet than aligning herself with the values of allopathic medicine. Most important to this scenario is the immediate negative appraisal of Janet by her health care providers and their lack of an attempt to understand Janet’s choices and values.

There is a growing body of literature that supports the importance of honoring and cultivating emotional and social intelligence alongside the intellectual knowing that occurs for most health care practitioners (Freshman & Rubino, 2004). Indeed, science alone brings to mind images of a robot performing rote tasks and algorithms, not of one human offering compassionate care and understanding to another. The goal of attaining knowledge should be more than memorizing lists, formulas, and facts. In order to incorporate humanitarian values into health care, those who are training to provide that care need to learn how to critically reflect, engage with others compassionately, and acquire an understanding of social issues and how they affect individual choices and responses (Kumagai & Lypson, 2009).

Cultivating Reflective Practice as Critical Inquiry

Ellen was graduating from university and had been given an award by her faculty for her stellar scholarship while in her program of study. Ellen would receive this award at the end of the year banquet that was hosted by the Dean of the University. While Ellen came from a white upper-middle-class background and her parents had paid for her education, her father had not agreed to her choice of her major. Although he continued to pay for her tuition through a savings plan that he had set up for her university education when she was younger, he made it clear to her that he wanted “nothing to do with these liberal university types.” When Ellen was notified of the award, she felt deeply honored. However, the end of the year banquet cost $75 per person, and she could not afford to pay this amount on her own. She was afraid to ask her parents for the money because of the conflict with her father over her academic choices. Ellen was surprised when one of her professors, a middle-aged black woman, handed a banquet ticket to her after one of her classes. Ellen felt embarrassed, but grateful. When she asked how the professor knew that she was struggling with obtaining the money for the dinner, the professor smiled and told her, “now you understand how one person can make a difference.” Her professor was capable of looking beyond Ellen’s apparent
privilege and most likely her own relation to it as a black woman who was similar in age as Ellen’s parents. Her ability to do this afforded Ellen an opportunity to do the same.

Many disciplines have now integrated the concepts of reflective practice into their curricula and continuing education programs. To reflect on our practice with the individuals we serve in our professional capacity, we have to be willing to cultivate awareness and understanding of ourselves and how our backgrounds shape our responses, in addition to being willing to “step out” of a situation in order to see things that are happening in a holistic and open way. For many, the ability to reflect is second nature—something that is just an extension of their personality and daily practice. However, for others, reflection needs to be learned and structured (at least in the beginning). Reflective practice has been linked to enhanced professional competence and to more effective delivery of care, which is why it has become a requirement for many professionals in their ongoing practice (Plack & Greenberg, 2005).

All professional settings have a “culture” established within them, whereby certain behaviors are expected, reinforced, and habituated. For example, most professional offices require an appointment for consultation. Patients are expected to disclose sensitive personal information to professionals in exchange for their services and the anticipation of improvement. Hospitals typically have “visiting hours” and intensive care units usually have posted rules regarding who can visit someone in the unit, at what times, and under what circumstances. In all professions, we become attuned to a specific way of thinking and to language and jargon that are associated with our field of knowledge. In nursing and medicine, the use of the scientific model and the ability to accurately and objectively describe findings, symptoms, and data are valued. In therapeutic professions such as social work, psychology, and counseling, the ability to embed experience into theoretical frameworks and models of meaning making are important. Spiritual care professionals become familiar with existential language, religious symbols, and philosophical dilemmas that are relevant to the clinical care settings in which they practice. Most of the rules, jargon, and expectations in these situations are implicit; they are simply understood to be part of the milieu of the professional environment. However, these familiar protocols, terms, and symbols can readily become barriers to individuals not familiar with the language and expectations that are part of the everyday world of the professionals who function within them.

Clinical work that is rooted in social awareness explores how issues of power are manifest in the life of the individual (Aldorondo, 2007). Innate in this exploration is the concept of empowerment, which is described as a process of dialog through which the client/patient is continuously supported to explore the range of possibilities that she or he sees as appropriate to his or her needs. In an empowerment model, the client/patient is identified as the “expert,” and his/her subjective experiences and perceptions form the center for all decisions that are made in the therapeutic setting (Rose, 1990). It is important to note that an empowerment model seeks to identify sources of oppression, validates subjective experiences that have been objectified or marginalized through oppressive forces, focuses upon innate strengths and resilience, and supports advocating for social change to address oppression at the structural level (Gerber, 2007; Lee, 2007).

Let’s go back to the examples that were given at the beginning of this chapter and consider them from a critical perspective.

Janet’s choice not to take chemotherapy after she was diagnosed with breast cancer:

1. What are the power issues in this situation?
2. Are there issues of race, class, or gender, or historical oppression/discrimination in this situation?
3. What might Janet’s choice to not utilize allopathic medicine convey to the health care providers?
4. What are the underlying social expectations that would come into play in this situation?
Amy’s experience of the two black girls in her dorm:

1. What are the power issues in this situation?
2. Are there issues of race, class, gender, or historical oppression/discrimination in this situation?
3. What explanation might inform Amy further about the girls’ response to her?
4. What are the underlying social expectations that would come into play in this situation?

Alma’s family’s choices regarding her care:

1. What are the power issues in this situation?
2. Are there issues of race, class, gender, or historical oppression/discrimination present in this situation?
3. What might inform the care providers further about the family’s decision?
4. What are the underlying social expectations that would come into play in this situation?

Conclusion

There are many ways in which a critical view is important in the context of death, dying, loss, and grief. As you read the rest of the book, we invite you to consider the contextual pressures and elements that exist all around you in your everyday life. Think about how your choices and the choices of those around you are influenced by social forces and shaped by issues of social power dynamics. Thinking critically about all aspects of life and death is not just about applying a set of questions to specific situations, but more about a way of thinking and being in general, where the contextual elements of the everyday life are recognized and understood for their importance. Over time, developing critical consciousness can become second nature. Instead of it being something that you “do,” it is becomes a part of who you are. Once you cultivate this level of awareness, you will never see the world (and the people in the world) in the same way as you did before, and this awareness may become one of the most compassionate forces in your work.

Key Terms

_assumptive world_—internalized explanations about how the world works, expectations we have in our interactions with others, and our view of ourselves in relation to others; based primarily on early attachment relationships/experiences.

_critical consciousness_—reflective awareness of the differences in power and privilege and the inequities that are embedded in social relationships.

_power_—within a social context, the ability to have influence, control, superiority, or an advantage over others. On an individual basis, the freedom to choose and/or having access to a larger array of options than is available to those with less power.

_total pain_—the multidimensional nature of pain includes the physical, psychological, social, and spiritual domains that are part of the experience.

Questions for Reflection

1. What are some of the power dynamics that are at play in your life? Consider your involvement (direct and indirect) with employers/employees, family members, government, neighbors, faith communities, strangers on the bus, and everyday interactions.
2. At each stage of growth and development we learn things about ourselves and the world, much of which we adopt in a fairly unconscious way . . . unless we are introduced to conflicting information. What are some early beliefs you have changed/challenged through ongoing learning? What led you to challenge this initial information?
3. People in Western society shy away from knowledge they cannot verify, which leads to exclusionary thinking and privilege towards linear thinking. . . . Individuals who show more emotion, who don’t formulate their knowledge by the scientific method, or who do not excel in typical academic pursuits have less social power than those who do.

(p. 26)

What is your response to the role of intellectual privilege in Western society? To what extent do you employ other ways of knowing in your daily life? What is your primary way of knowing? What is your experience when interacting with others who seem to draw primarily on a different way of knowing?

References


