CHAPTER CONTENTS

3 Theoretical Contributions of Interpretive and Critical Research in Health Communication

Heather M. Zoller
University of Cincinnati

Kimberly N. Kline
University of Texas at San Antonio

Health communication researchers have made great strides in developing theoretically grounded research, resulting in more complex understandings of communication in health contexts. Integral to these developments has been the burgeoning use of interpretive and critical perspectives. Yet, we still lack a broader description and assessment of the contributions of interpretive and critical research to theory and practice in health communication. Such an assessment is important, given that the nature of these contributions differ at times from post-positivist research (in some cases overlapping, in others acting complementarily, and still others antagonistically). Thus, in this chapter, we describe the unique elements of interpretive and critical contributions in the extant literature and assess these contributions to identify ways in which they can be strengthened. Though we primarily draw on U.S. literature, this scholarship comprises interdisciplinary, international, multi-methodological, and cross-cultural research in an array of communication contexts (intra- and interpersonal, small group, organizational, mass-mediated). Thus, this chapter not only provides a comprehensive review of the ways in which interpretive/critical approaches have been utilized in health communication research across a range of global contexts and concerns; it also builds an overarching argument with regard to the contribution of interpretive and critical approaches that is germane to the study of communication in general.

In the 1980s, many scholars in the field of health communication complained of a lack of theory-driven work and simplistic views of communication (Thompson, 2003). In the 1989 inaugural issue of the journal *Health*

Correspondence: Heather M. Zoller, University of Cincinnati, Cincinnati OH 45221-0184; Phone: 513-556-4468; Fax: 513-556-0899; E-mail: Heather.Zoller@uc.edu. Kimberly N. Kline, University of Texas at San Antonio MB 2.312, One UTSA Circle, San Antonio, TX 78249-0643; Phone: 210-458-5990; E-mail: kim.kline@utsa.edu

Communication, Editor Teresa Thompson (1989) also noted the need for health communication research to be more socially relevant and useful to practitioners. Health communication was, at that time, a relatively new area of scholarship stemming from research in other academic disciplines, especially behavioral science, (social) psychology, but also sociology, anthropology, political science, and even history (Rogers, 1996; Thompson, 2003). Within the field of communication studies, health communication scholars often got their start in interpersonal and mass communication studies (Ratzan, Payne, & Bishop, 1996). Essentially, these scholars drew from their disciplinary commitments, but they were particularly interested in health-related issues and contexts. Since then, health communication researchers have made great strides in developing theoretically guided research grounded in more complex understandings of communication.

We believe the burgeoning use of interpretive and critical perspectives in health communication research has been integral to these advancements. Only a decade ago, John Tulloch and Deborah Lupton (1997) lamented that "the field of health communication could potentially incorporate social and cultural theory in understanding how individuals make sense of and experience medicine, health and disease" and opined that "such theory has received little attention" (p. 16). We argue that, in just 10 short years, these perspectives have become more mainstream rather than "alternative" in contemporary research practices.

We feel that a delineation and assessment of the contributions of interpretive/critical research is important, given that the nature of these contributions often differs from post-positivist research (in some cases overlapping, in others acting complementarily, and still others antagonistically), and that what counts as a theoretical contribution depends on one's worldview.[1] In this chapter, we describe the nature of interpretive and critical contributions, assess these contributions to understand how these perspectives are being applied, and identify ways in which they can be strengthened.

Though this chapter focuses on health communication, it also speaks to the communication discipline more generally. First, health communication provides a useful example of the growth of intra- and inter-disciplinary research in the field of communication. Health communication clearly intersects with other areas of communication. For example, scholars may study interpersonal health issues, health organizations, mediated health messages, and the like. Further, it draws from and contributes to other disciplines as well (e.g., biological sciences, sociology, public health). Indeed, in this chapter, we refer to scholarship that others may not necessarily consider to be "health communication;" we include this research because it employs interpretive/critical approaches to address issues of health and illness along with communication. (Conversations with colleagues suggest that some scholars working on health issues do not label their research as health communication because of lingering perceptions of the field as a

post-positivist domain.) This chapter highlights interrelationships between health and issues and concerns across the discipline.

Second, health communication constitutes a model for areas of the discipline that have not yet grappled with the application of theories and concepts across cultures. The field addresses international health concerns and, as a result, works across national boundaries. Indeed, U.S.-based journals and publications give escalating attention to health concerns in multiple countries, particularly Africa, Australia, India, and Mexico (Diop, 2000; Dutta & Basu, 2007; Harter, Sharma, Pant, Singhal, & Sharma, 2007; D. Johnson, Flora, & Rimal, 1997; Storey, Boulay, Karki, Heckert, & Karmacha, 1999; Witte, 1998). Third, because we argue that the theoretical contributions of interpretive research should be evaluated differently than post-positivist research, this examination itself may act as a model for the broader discipline. This chapter provides a comprehensive review of the ways in which interdisciplinary interpretive and critical approaches have been utilized in health communication research across a range of international contexts and concerns; in doing so, it speaks to the role that these perspectives play in the study of communication in general.

We begin this chapter with the historical development of interpretive/critical research in health communication, and we then describe the theoretical underpinnings of this research and the perspectives that contribute to these paradigms. In our analysis, we articulate how interpretive and critical research has contributed to our understanding of health communication theory and praxis using research exemplars. We conclude by evaluating these contributions and describing how future research can expand them.

DEVELOPMENT OF MULTIPLE PERSPECTIVES IN HEALTH COMMUNICATION

Like other areas in communication, early research in health communication was marked by mostly post-positivist (often quantitative) studies of cognitive-behavioral variables. The discipline was motivated by its roots in epidemiological research to determine the "behavioral and psychological variables important to the process of prevention and adopting healthier behaviors" (Finnegan & Viswanath, 1990, p. 17) as well as the psychological orientation of interpersonal research (Ratzan et al., 1996) and the scientific perspective of medical research (Rogers, 1996). As a result, quantitative/cognitive-behavioral approaches came to be understood as the "traditional" approach and qualitative/interpretive-critical approaches as the "alternative" approach (Burgoon, 1995).

Many early insights into social constructionist approaches to communication issues in health came from outside the discipline. Even before communication scholars recognized health communication as an important sub-area of the discipline, historian-philosophers Michel Foucault (1973) and Ivan Illich (1976) and medical sociologist Irving Zola (1972) interrogated the sociopolitical

discourses of health, illness, and medicine that led all three to critique the powerful influence of the so-called medical establishment in disciplining the individual body and, thus, members of society. Around the same time, Susan Sontag's (1978) pioneering book, *Illness as Metaphor* (see also Sontag, 1990), delineated the moralizing function of cultural metaphors for illness. Medical journalist Lynn Payer (1992) described the promotional discourses of medicine in her book, *Disease-Mongers: How Doctors, Drug Companies, and Insurers Are Making You Feel Sick*. Physician-sociologist Howard Waitzkin (1991) had an important influence, introducing a critical analysis of doctor-patient communication that described how these interactions reinforce dominant ideologies. Sociologist Lupton (1994c) addressed the role of culture in the experience of health, and her article in *Health Communication* (1994d) called for researchers to address systematic issues of power related to the practice of health communication.

Within the discipline, a special issue of the *Journal of Applied Communication Research* edited by David Smith (1988b) included articles that discussed the central role of communication in understanding the relationship between health and values (see D. H. Smith, 1988a) and critiqued health campaigns for their failure to address issues of power (McKnight, 1988). Later, Patricia Geist and Jennifer Dreyer (1993) introduced a dialogic framework to understand provider–patient interactions. In media studies, Barbara Sharf and colleagues (Sharf & Freimuth, 1993; Sharf, Freimuth, Greespon, & Plotnick, 1996) sought to understand the rhetorical construction of illness in primetime television, offering an audience analysis of viewer interpretations and a textual analysis of media messages.

These publications created pathways for additional inquiries into relationships among communication, meaning, and health from interpretive and critical perspectives. In our chapter, we highlight the immense growth in this area of research. First, we define and describe the philosophical and methodological underpinnings of these approaches.

Defining our Terms: What do we Mean by Interpretive and Critical Approaches?

Most broadly, at the metatheoretical level, approaches to research can be positioned on a paradigmatic continuum that takes into account variations in ontological, epistemological, axiological, and methodological assumptions. Numerous examinations of paradigmatic differences exist; scholars compare and contrast in the context of organizational (Burrell & Morgan, 1979), cultural (Martin & Nakayama, 1999), and interpersonal (Leeds-Hurwitz, 1995) studies; some make the case for complementarity of associated qualitative and quantitative methodologies (Deetz, 2001), and still others challenge their compatibility (J. K. Smith & Heshusius, 2004). Rather than reiterate these discussions, this section sets the parameters of research considered in this chapter. Notwithstanding their differences, discussions of meta-theoretical

paradigms generally acknowledge post-positivism (or, at its most extreme, positivism) at one end of the continuum and interpretive/critical at the other. Though we do not want to reify dichotomies or reinvigorate tensions, these paradigms define contributions to the field differently because definitions of theory, research goals, and practical orientations often vary.

Both interpretive and critical approaches start with the most basic ontological assumption that our perceptions of reality are constituted as subjects attach meaning to phenomena and that these meanings arise through interactions. The concomitant epistemological assumption affirms that we come to agreement about what is real intersubjectively. As Lupton (2000) described, "[F]or most social constructionists, the types of knowledges that are developed and brought to bear upon health, illness, and medical care may be regarded as assemblages of beliefs that are created through human interaction and preexisting meanings" (p. 50).

Because of their foundational, ontological, and epistemological assumptions, interpretive scholars strive to better understand interpretation and the process of meaning making. Scholars consider such research to be interpretive because they "are concerned with…describing the subjective, creative communication of individuals, usually using qualitative research methods" (Martin & Nakayama, 1999, p. 5). This perspective seeks to provide in-depth understanding of lived experience or a unique, well-argued and defended interpretation of a discourse to impart some insight into the multiple ways in which communication fosters particular meanings. Interpretive/critical scholars do not necessarily attend to (in)accuracy or rightness/wrongness of messages as measured against some objective reality. Rather, they engage in the double hermeneutic (Giddens, 1984) of interpreting others' interpretations, remembering that the phenomena we study in the social sciences are socially constructed (see related review by Bartesaghi & Castor, this volume).

Where interpretive scholarship offers "thick description" of communicative activity (see Geertz, 1973), critical scholarship also asks us to take an ethical position with regard to the implications of that communicative activity. We can distinguish between interpretive and critical research by employing the concepts of "consensus" and "dissensus" (Deetz, 2001). According to Deetz, researchers orienting near the "consensus" pole— interpretive scholars—"seek order and treat order production as the dominant feature of natural and social systems" (p. 14); trust and concerns with harmony characterize this approach. Researchers associated with the "dissensus" pole—critical scholars—"consider struggle, conflict and tensions to be the natural state" (p. 15); the approach features concern with the privileging of interests by particular constructions of reality. Thus, both approaches assume socially constructed realities, but interpretive perspectives tend to focus on describing and understanding those realities; whereas, critical ones challenge dominant orders and aim to unmask and reclaim hidden conflicts. With regard to health communication, "the critical perspective takes an overtly political approach, questioning the values of biomedicine and focusing on the identification of political, economic, and

historical factors that shape a culture's responses to and concepts of health, disease, and treatment issues" (Lupton, 1994d, p. 58).

Critical theorizing involves deconstructing dominant, taken-for-granted assumptions about health, often with the hope of introducing possibilities for alternative, more inclusive meaning systems. These perspectives emphasize the role of human-made systems of meaning but link these systems to material consequences for people's lives (Waitzkin, 1991). This scholarship serves a crucial function for the field of health communication, which sometimes assumes that researchers' goals of health improvements are an "unquestioned good" (Rogers, 1996, p. 18). Critical research gives attention to issues of power, inequality, class, and other differences that may be overlooked in more functionalist research (Deetz, 2001; Lupton, 1994d; Mumby, 1997). Theorizing proceeds by examining how communication in health contexts creates, reproduces, or challenges dominant power relations.

The criteria for judging the credibility and validity of interpretive/critical scholarship are distinctive from post-positivist research (Patton, 2002). Whereas post-positivist scholars hold that theories must be predictive and generalizeable, interpretive scholars tend to view theory as more contextually bound, as a dialectic between local and more general understanding (Martin & Nakayama, 1999). With regard to ethnography, for instance, "the essential task of theory building here is not to codify abstract regularities but to make thick description possible, not to generalize across cases but to generalize within them" (Geertz, 1973, p. 56). Thus, depth of insight into local constructions constitutes a key way to assess interpretive research. As Patton noted, we can evaluate interpretive research in terms of process, such as the openness of researchers' relationships with subjects and their reflexivity in addressing their own role in data gathering and analysis. Patton contended that contributions to praxis, or theoretically informed social change, mark another important means of evaluating "alternative" research. For critical scholarship, praxis involves pursuing connections between local practices and larger systems of power to facilitate change (Lupton, 1994d).

Despite the emphasis on local knowledge, we argue that interpretive/critical researchers should maintain a systematic approach to building health communication theory. The focus on contextualization does not rule out some level of generalization or the need for theories that cut across individual contexts. Geertz (1973) suggested that theory building can be seen as an activity "[b]etween setting down the meaning particular social actions have for the actors whose actions they are, and stating, as explicitly as we can manage, what the knowledge thus attained demonstrates about the society in which it is found and, beyond that, about social life as such" (p. 57). Thus, in interpretive/critical studies, "[p]articular persons and situations are artifacts used to understand the system of meanings through which particular persons and situations are composed and connected to the larger sociocultural context" (Deetz, 1992, p. 85).

This view is consistent with Austin Babrow and Marifran Mattson's (2003) description of theorizing as, in part, "an inherently communicative process by which we attempt to formulate a consciously elaborated and justified understanding of the world" (p. 37). As we examine the contributions of individual studies, we discuss the degree to which research, individually or taken as a body of literature, contributes to broader issues of health and illness as well as insight into the case under study.

Three caveats are in order regarding comparisons between interpretive/critical theorizing and post-positivist theorizing. First, interpretive/critical approaches may seem synonymous with qualitative methodologies (and, alternatively, post-positivist approaches synonymous with quantitative methodologies); in research practice, however, they are not always the same.[2] In our view, the approach to analyzing and understanding data, not the strategy for *collecting* data, distinguishes between post-positivist and interpretive/critical research. Second, the focus on local, in-depth knowledge in interpretive methodologies leads some to view this research as pre-scientific, as hypothesis generators that require validation and generalization (Bowers, 1972; J. B. Brown, Stewart, & Ryan, 2003). However, it could just as well be argued that quantitative research is pre-interpretive, given that generalized findings require investigation of local interpretations of elite operational definitions and conclusions. In other words, the goals of generalizability and depth of insight can work in complementary ways among various research traditions, and no single approach needs to be privileged. Third, we described a dialectic between local understanding and more general insights in interpretive/critical research; we note similar tensions in post-positivist research that aims towards generalization through atomistic methods. Social-scientific scholars often criticize variable analytic research when it does not attempt to build and test communication theories (Witte et al., 1996). So, despite differences, the paradigms share some similar concerns.

In sum, this section illustrates useful distinctions between interpretive and post-positivist research (metatheoretical commitments, goals, and assessment criteria) as well as parallel concerns (methodology and legitimacy). This understanding of differences and commonalities can help to maintain a cohesive discipline in the face of heterogeneous approaches. In the next section, we describe the various research traditions that constitute interpretive/critical studies.

Research Traditions in Interpretive/Critical Research

The multi-disciplinary, multi-conceptual, multi-methodological, multi-topical —indeed, the multi-theoretical—approaches in the studies to which we refer make it challenging to parse them in terms of their theoretical lens. A single study often represents several different theoretical commitments. (For example, one study might be social constructionist, grounded, and employ a particular theory for analysis.) Even within a philosophical paradigm, numerous,

sometimes overlapping, foci garner the attention of researchers and serve to direct attention to different aspects of communication phenomena (Craig, 1999; Patton, 2002). Moreover, the research to which we refer often did not overtly state a theoretical perspective. For instance, Bartesaghi and Castor (this volume) noted that social constructionist research routinely reflects the tenets but does not invoke the specific term. As we review relevant research, we infer the theoretical approach from authors' discussion. In this section, we briefly describe these perspectives to provide background for our discussion of their contributions.

Rhetorical perspectives are largely concerned with the suasory potential of communication. Whether subscribing to a more Aristotelian conceptualization of rhetoric (i.e., rhetoric as the available means of persuasion of logos, ethos, and pathos) or a Burkean conceptualization (i.e., rhetoric as a means of inducing cooperation through identification), research in this vein concentrates on rhetorical situations and, hence, the *appeals used* by rhetors (Lupton, 1992; Signorielli, 1990). The suasory implications of a text/discourse may be the result of the carefully crafted and consciously strategic efforts of the rhetor (as in advertising or health campaigns) or the unconscious but implicitly persuasive actions of rhetors (as in journalism or entertainment media) (Kline, 2003, 2006). In either case, the rhetorical scholar presumes that a rhetor "has selected certain material and certain arrangements to accomplish a purpose" (Andrews, 1990, p. 47). Rhetorical research usually involves textual analytic methods.

Narrative research is often, though not always, aligned with the rhetorical perspectives (Fisher, 1987). Narrative perspectives in health communication comprise one of the strongest trends in current interpretive research (Frank, 1995; Greenhalgh & Hurwitz, 1998; Kleinman, 1988; Sharf & Vanderford, 2003). As evidenced by the edited book *Narratives, Health, and Healing* (Harter, Japp, & Beck, 2005a) and other research, narrative can be used as a method for analyzing discourse (Arrington & Goodier, 2004) and interpersonal dialogue (Rice & Ezzy, 1999), a methodology for communicating personal experience (Rawlins, 2005; Sharf, 2005), and a theoretical perspective that focuses on the ways that humans construct the meaning of objects, on-going events, and personal and social identity through plotting and use of storytelling (Babrow, Kasch, & Ford, 1998). Narrative theories point us away from transmission models of communication and assumptions of rational logics as they show us how people make sense of and explain their world through the use of narrative logics. In this view, stories constitute "both mundane and extraordinary ritual symbolic forms," and they provide "sites for action and agency" (Harter, Japp, & Beck, 2005b, p. 9).

Grounded theorizing is another important trend in health communication (Beck et al., 2004). It emphasizes allowing the themes, categories, and issues of concern to emerge from research participants themselves rather than beginning research with issues and concepts defined by the researcher (Charmaz, 2002; Glaser & Strauss, 1967). Ethnographic perspectives are also grounded, but they arise from hermeneutic and phenomenological commitments that

emphasize human interpretation of local meanings as a methodology (Geertz, 1983; Rawlins, 1998). Ethnographic work seeks to learn about culture by attempting, as much as possible, to understand the construction of meaning from the perspective of cultural members through observation and participation (Geertz, 1983). The perspective provides insight into everyday communicative health practices and relationships between culture and health (DeSantis, 2002; Ellingson, 2005; J. L. Johnson et al., 2004).

Dialogic perspectives have helped to bring a relational focus to a field often focused on messages. Research from a dialogic perspective investigates the co-construction of meaning through the flow of ongoing interaction (Cissna & Anderson, 1994). Dialogue is rooted in voicing otherness and acknowledging differences, and it involves genuine listening and willingness to be changed in interaction (Bakhtin, 1981, 1993; Buber, 1958; Cissna & Anderson, 1994). Health communication scholarship examines practical attempts at dialogue such as community health planning (Zoller, 2000) as well as evaluates discourse and interaction such as provider–patient interactions by comparing it to the ideals of dialogue (Geist & Dreyer, 1993).

Critical perspectives in communication include several traditions. The cultural studies tradition emphasizes the culturally situated nature of health communication interactions and processes and locates culture in the realm of structure and power (Dutta, 2008). For example, critical studies of media illustrate how ideologies of health and illness produce social knowledge in ways that reflect dominant cultural constructions that legitimize dominant power relationships (Lupton, 1995). Likewise, scholars using the label critical or critical-interpretive investigate how everyday taken-for-granted assumptions about reality reinforce dominant power relationships and how communication may resist or alter those power relationships (Mokros & Deetz, 1996). Both cultural studies and critical interpretive scholars are influenced by the Marxist tradition, including Frankfurt school theorists, Italian theorist Antonio Gramsci, as well as Stuart Hall and the Centre for Contemporary Cultural Studies (Mumby, 1988). Other branches include postcolonial theory (Spivak, 1999), feminist studies (Dow & Condit, 2005), and queer theory (Yep, Lovaas, & Elia, 2003).

Critical approaches may draw from postmodern theories as well. *Postmodernism* is a contested term that itself represents a number of potential research orientations. Here, we reference work that shares a suspicion of meta-narratives, including a questioning of unified conceptions of the self (Lupton, 1995; Mumby, 1997). Postmodern theorizing interrogates the relationship between power and the construction of knowledge, often focusing on the micropolitical level, understanding everyday instances of power and resistance (Deetz, 2001). Postmodern theorists tend to focus on deconstruction, reclaiming and celebrating conflict, rather than articulating a preferred ideology or social configuration as those with more Marxist commitments might (Deetz, 2001; Waitzkin, 1991). Despite differences in both labels and approaches, critical scholars share concern with issues of power, ideology, and domination, as well

as resistance and emancipation. With this understanding of what constitutes interpretive/critical research, we now describe how we developed our discussion of the theoretical contributions that extant work makes to the field of health communication. We then describe these contributions using research exemplars.

THEORETICAL CONTRIBUTIONS OF INTERPRETIVE/CRITICAL RESEARCH

Rather than sets of predictive theories, theoretical contributions from interpretive/critical research focus on the development of insight. In their description of social constructionist research, Babrow and Mattson (2003) argued that it contextualizes discourse, identifies contrasting perspectives, incorporates cultural sensitivity, and reveals what is rhetorical. We used these ideas as guides, expanding, altering, and adding categories as we gathered significant examples of interpretive/critical work from various theoretical traditions. These inductive categories illustrate theoretical advancements represented in the work. Of course, these categories are interconnected and overlapping, but each sheds light on a different value imparted by the research. Our list focuses directly on issues of health, but we believe the contributions themselves can be applied in the broader discipline. We discuss this application in the conclusion.

Uncovering Everyday, Contextualized Experiences of Health and Illness

Interpretive research (including grounded theory, ethnographic, case study, discourse analysis, and narrative methodologies) expands our understanding of the everyday experience of health communication processes. Interpretive scholarship demonstrates the ways that individuals define and make sense of health and illness through factors such as personal experiences, interpersonal negotiations, cultural backgrounds, and class frameworks, much more so than by some externally defined biomedical criterion. These personal views of health provide important foundations for how people interpret health information and directives. Critical perspectives contextualize these everyday constructions within social and political structures. In this section, we provide exemplars in the areas of the interpretation of health, the experience of illness, and medical interactions.

Everyday Definitions of Health and Illness

Before we can promote "health," we need to understand how diverse groups and individuals define and experience the concept in every day life. Grounded

and ethnographic perspectives shed light on this process by acknowledging differences in what constitutes health and healthy living, particularly when considering gender, social class, and culture. For example, Australian women viewed their children's health and well-being (and even intelligence and other outcomes) almost exclusively in terms of their own vigilance, planning, and effort (Lupton, 2008). These beliefs reflect dominant health promotion messages aimed at mothers and do not consider notions of luck or fate that might also play a role in defining health. Critical research can uncover the class assumptions in definitions of health; Zoller (2004) found that some members of the working class may be more likely to define health as release (i.e., doing what one enjoys) (see also Crawford, 1984), focusing on sports and fun and ignoring disciplinary approaches associated with middle-class values that define health in terms of hard work and self-control.

Culture-centered research elucidates how Western, often biomedical, health concepts fail to address the perspectives of non-Western cultural groups that may place more value on family, society, spirit, and nature than individual biology. For instance, Latina women on the Texas-Mexico border describe the importance of family to their conceptions of health and illness (Villagran, Collins, & Garcia, 2008). Dutta-Bergman (2004) used ethnography to understand the polymorphic health beliefs of the Santalis in India, describing the tensions that they experienced between maintaining traditional views of health as a balance with nature and accepting dominant scientific frameworks.

Contextualized research into health constructions among social groups helps us to understand how deeply rooted norms for health values and behaviors may develop, and they highlight the "non-rational" ways that health promotion messages may be interpreted in light of emotional and social needs. For instance, patrons in a cigar shop collectively rationalized smoking behavior through their shared narratives and, in doing so, created barriers to anti-smoking arguments (DeSantis, 2002). Health promotion campaigners must account for these group stories and the needs that they meet, which are not met by PSAs and other education material.

Illness Experiences

Interpretive researchers also illuminate everyday communication processes related to illness experience. Ethnographic work examines the experience of social support for people with illnesses in hospice situations (Adelman & Frey, 1997) and support groups (Arrington, 2005). Narrative perspectives, in particular, build knowledge of how people negotiate and make sense of illness experiences (Frank, 1995; Gibbs & Franks, 2002; Greenhalgh & Hurwitz, 1998; Harter et al., 2005b; Kleinman, 1988; Ott Anderson & Geist Martin, 2003; Sharf & Vanderford, 2003; Vanderford, Jenks, & Sharf, 1997; A. J. Young & Rodriguez, 2006). Narrative approaches do not formulate a singular theory of illness experience because, as Harter et al. asserted, "[e]ngaging in narratives require scholars to delve

more deeply into murky, cluttered, and complicated interrelationships between sometimes incompatible issues" (p. 8). This narrative engagement shows us *how* humans construct meanings associated with illness through plotting and use of storytelling. Ott Anderson and Geist Martin detailed how one couple's narrative after a cancer diagnosis elucidated the processes through which they constituted supportive relationships and established the central role of family communication in forming and altering illness identities. Their study revises the discrete illness identities proffered in emotion and identity management theories (victim, warrior, survivor), finding a "continuous, multifaceted process" (p. 141) of identity formation. Building on this insight, Christina Beck's (2005) analysis of Cathy Hainer's news columns about her breast cancer experience concluded that "health narratives are necessarily embodied rhetoric—powerful, persuasive, deeply personal yet inherently social," theorizing that people make choices about how they talk about their illness "in the relational context of what others might think or how they want to construct individual or relational identities in light of such others" (p. 79).

By grounding theory about illness in the experience of those who are ill, interpretive perspectives generate new understanding of social problems. McGrath (2005), a researcher from an Australian school of nursing, sought to "deepen our understanding of how individuals construct their spirituality in the face of life-threatening illness" (p. 217). She found that the nonreligious lack a shared language to describe illness but also determined that shared experiences could form the basis for such language. This study is noteworthy because this absence would be difficult to measure using postpositivist research methods. Critical perspectives challenge elite definitions of social problems, allowing marginalized groups to define their experience, such as the unique problems of sick people who face economic barriers to care (Gillespie, 2001).

Medical Interactions

Research into the everyday experience of medical care and provider–patient communication illustrates how participants accomplish issues of illness, identity, and compliance through interaction. Also, interpretive/critical research often broadens our theorizing by including less powerful participants in the medical process. Interpretive and critical work addresses effectiveness, but, because it does not privilege provider perspectives, it also introduces other concerns, such as whose agenda prevails in interaction (Sharf & Freimuth, 1993), how provider communication is interpreted (Dillard, Carson, Bernard, Laxova, & Farrell, 2004; Hines, Babrow, Badzek, & Moss, 1997), or how technological discourse influences decision making (Keränen, 2007).

Sharf (1990) paved the way for approaching the interpersonal dialogue between a doctor and a patient as a rhetorical situation in which each participant has a rhetorical agenda. Subsequent work has used narrative (Eggly, 2002; Ellingson & Buzzanell, 1999; Greenhalgh & Hurwitz, 1998; Sharf & Vanderford,

2003) and dialogic lenses (Ellingson & Buzzanell, 1999; Geist & Dreyer, 1993) to investigate the complexities of interaction and the possibility of more open and mutual agenda formations. This research may revise dominant models of medical communication; for example, narrative-based medicine could transform palliative care by focusing on the situational, emotional, cultural, and moral needs of patients (Ragan, Mindt, & Wittenberg-Lyles, 2005). Likewise, physician communication about end-of-life decisions among the elderly would be improved using the theory of problematic integration (Hines et al., 1997).

Interpretive perspectives foster attention to actual, everyday communication and interactions among multiple health care workers (Geist & Hardesty, 1992). In a year-long qualitative observation of emergency departments, Eisenberg et al. (2005) found that departments consistently substituted technical rationality for patients' narrative rationalities in ways that contributed to medical mistakes (see also Keränen, 2007). Ellingson (2003) used Goffman's theory of dramaturgy to research the "backstage" teamwork of an interdisciplinary geriatric oncology team at a cancer center (see also Ellingson, 2005). She concluded that studies of interdisciplinary health teams fail to account for informal interaction by focusing on formal meetings (thereby privileging public, "masculine" forms of communication). Backstage communication about patients can influence caregiver perceptions of patients before they meet them in both positive and negative ways.

In sum, interpretive perspectives focus on communication in everyday life, thereby providing rich accounts of health communication processes as people constitute and interpret the meaning of health and illness and negotiate medical care from interpersonal to organizational settings. These studies capture moments of ongoing interactions and, as such, they are not generalizeable or predictive in any simple fashion. Yet, these studies add complexity to our understanding of health behaviors, including the role of culture, values, and emotion, and they offer a counter-balance to the individualizing tendencies of post-positivist research. We should strengthen connections across these works to build systematic theorizing about the implications of meaning construction in health interactions.

Understanding the Mediated Construction of Health Meanings

Interpretive/critical research attends to the manner in which *discourse* is constitutive of personal, social, political, and economic influences (and, in this case, health and illness). In part, discourse includes intra- and interpersonal dialogue but, in this section, we refer to the messages and meanings produced for "the masses" that mediate understandings. Interpretive/critical scholars pursue the ways in which media representations produce and reproduce social knowledge (Hall, Hobson, Lowe, & Willis, 1980; Seale, 2004b). Notably, such scholars assume that media producers frame social (health) "problems"

and "solutions" in such a way as to privilege certain interests while deflecting attention from other (marginalized) interests. Interpretive/critical media research presumes that mass media messages influence, maintain, perpetuate—indeed, constitute—knowledge and values (Kline, 2003). Understanding this production of knowledge requires close interrogation of the implied meanings in all forms of mass media.

Like most interpretive/critical research, media research is frequently interdisciplinary, combining rhetorical, semiotic (Knuf & Caughlin, 1993), linguistic, media theory and method, the rhetoric of science, medical anthropology, sociology, and historiography. In health communication, the preponderance of interpretive/critical media research is textual analytic (for reviews, see Kline, 2003, 2006). In contrast to quantitative content analysis (esp. Signorielli, 1990)[3] which attends more to manifest meaning in mediated texts, interpretive/critical textual analysis delves into latent meanings, centering "attention upon the rhetorical devices and linguistic structure, the 'style' as well as the subject matter of verbal communications, and the manner in which ideology is reproduced in them" (Lupton, 1992, p. 145). Juanne Clarke's (1999) textual analysis of mediated representations of prostate cancer distinguished between manifest and latent content, assessing the manifest messages by gauging the number of messages that referred to early detection, cancer incidence, or treatment. Analysis of latent content, though, revealed a "gender wars" theme wherein the discourse expressed not just the need for more funding but frustration that breast cancer received so much attention (p. 67)—an insight that could have been missed in the initial assessment.

Interpretive/critical textual analysis attempts to identify thematic consistency in rhetorical choices and then consider possible implications (though not necessarily actual effects) given relevant information about the audience and/or social context of the rhetorical act. For instance, pointing out that popular media acts as an "unobtrusive source of health information for vast numbers of people" (p. 141), Sharf and Freimuth (1993) analyzed the ongoing storyline in the television show *thirtysomething* wherein a major character suffers from ovarian cancer to "construct [their] own reading of this text in the context of contemporary biomedical and cultural information regarding ovarian cancer" (p. 145). The authors described how the representations addressed various issues of information-seeking choices, self-image, sexuality, relationships with family and friends, relationships with doctors, and spirituality, and they noted missed opportunities for presenting additional information and perspectives that might be useful to a diverse audience. In other words, media researchers may make their case with regard to their interpretations of a text by citing evidence that media messages have, indeed, had an effect on social policies and individual experiences, but the primary research question focuses on how certain textual messages *invite* audience members to make meanings from a text. In the next section, we describe micro-analytic and macro-analytic studies of popular media (entertainment, journalistic, advertising) texts and

then discuss the emerging use of textual analytic methods to assess and revise health promotion texts.

Micro Analyses of Popular Media

Much of the interpretive/critical health media research addresses the micro-meaning of discourse in that it "emphasizes specific textual (spoken, written, visual or multimodel) practices and regularly isolates extracts of text for in-depth analysis" (Gwyn, 2002, p. 26). That is, scholars attend to a specific health topic as represented in specific (set of) media representations. For instance, Lupton detailed the ways in which such health issues as HIV/AIDS (1998, 1999), cholesterol (1994b), and condom use (1994a) are socially constructed in Australian newspapers. Notably, her discursive approach allowed her to focus on different aspects of the representations even as she analyzed the same topic/set of texts. In one study, Lupton (1998) discussed topical themes and found that the media generally portrayed HIV/AIDS as a biomedical, rather than public health problem, that affected gay men, as opposed to the general population. She suggested that, as a consequence of these issue frames, the press became less interested in the topic of HIV/AIDS (with concomitant implications for general attitudes toward the syndrome as well as public policy and funding decisions). In another analysis of the same news articles, Lupton (1999) identified three dominant archetypes used in reports of individuals with HIV/AIDS—the victim, survivor, and carrier. Her discussion of implications focused on what these representations revealed about "more general moral notions regarding the body, medicine, health and illness" (p. 41). Theoretically, each of these studies provides a contextualized understanding of how mediated messages create or reinforce knowledge about health issues and their potential influences on how individuals might think and act with regard to those issues.

Macro Analyses of Popular Media

Though investigations of "specific 'discursive' practices cannot fail to throw light on the wider cultural practices in which they are embedded" (Gwyn, 2002, p. 30), we also found interpretive/critical research that has more directly addressed the implications of mediated texts for broader discourses or macro meanings—that is, according to Gwyn, "entire modes of representation in culture" (p. 26). In his book, *Media & Health*, Clive Seale (2004b) concentrated on how the aggregate representations cohere in an overarching social narrative. He reviewed extant health media research and identified a meta-narrative in health media that emphasizes risks to the audiences, perpetuates the notions of villains and freaks (i.e., stigma), innocent victims (i.e., children), professional and ordinary heroes, and implicates gender in almost all aspects of the story. Thus, Seale demonstrated how mediated texts contribute to a broader social discourse of health, illness, and medicine.

Macro-level interpretive/critical research also recognizes the intertextuality of mediated communication (Ott & Walter, 2000), investigating its links with intra- and interpersonal, group, and organizational communication in the social/discursive construction of a health issue. Vanderford and Smith's (1996) book on the silicone breast implant controversy cogently illustrated the complex and dynamic communicative forces that impinge on health-related sense making and uncertainty. In chapters that employed a variety of methodologies, they described the experiences of women who were satisfied and unsatisfied with silicone breast implants, conflicting and conflicted personal stories of physicians, mass-mediated representations and public perceptions of the issue, organizational discourse in the form of press releases issued by Dow Corning, and even their own narrative of pursuing the project. Thus, macro-level interpretive/critical approaches to mass-mediated messages generally share an interest in the confluence of medium production values, hegemonic ideologies, and material influences that impinge on representational choices, as well as the audience power to negotiate understandings of the mediated messages, that combine for possible particular constructions and (mis)understandings of discursive acts (see also Baglia, 2005; Elwood, 1999; Gwyn, 2002; Scott, 2003).

Reformative Analysis of Health Promotion Campaign Messages

While most interpretive/critical health media research prioritizes the mediated production of social knowledge, some health communication researchers seek to explicitly identify, and then remedy, weaknesses in persuasive arguments. At the core, such researchers maintain that health promotion specialists must understand cognitive and behavioral variables that impinge on how individuals process health messages, but we must also attend to how health promotion specialists use audience-analytic findings to craft health information and promotion messages. Perloff and Ray (1991) content-analyzed HIV/AIDS educational literature directed at IV drug users and their partners and concluded that messages focused on risk and prevention but failed to address issues of self-efficacy. Likewise, Kline and Mattson (2000) noted the lack of self-efficacy messages in breast cancer early detection pamphlets. More recently, Kline (2007) used qualitative methods to assess the cultural sensitivity of breast cancer education materials designed for African American women. Using the PEN-3 model of cultural sensitivity as a theoretical framework to assess whether audience specific breast cancer education pamphlets incorporate messages and message framing that reflected a profound understanding of African American cultural values, she found that the pamphlets could be made more culturally sensitive in a number of ways.

Whereas many of the theories and models that ensue from cognitive/behavioral approaches often position mass media messages as an intervening variable in decision-making, interpretive/critical approaches treat mass media as phenomena worthy of extended analysis in its own right (Kline, 2003).

In doing so, this research also adds to the broader project of interpretive/critical research by deconstructing taken-for-granted assumptions reflected and constituted in mass-mediated representations of health, illness, and medicine. Thus, it expands and explicates the role of mass-mediated messages in fostering and/or inhibiting social knowledge about health and often seeks to redress problematic constructions. Much of this research engages extant mass media theories in the study of health communication, though it could do so more explicitly. Hazelton's (1997) study of Australian news reporting of mental health referred to the "media's capacity…to construct preferred reading positions through the use of particular discourses and genres" (p. 76). Reference to the idea of a preferred reading invokes a whole host of theorizing about audience meaning-making and pleasure (Hall, 1997); however, like many other media scholars, Hazelton's goal was not so much to extend this theory but to identify the preferred reading suggested by the representations. Overall, though, this review suggests that interpretive/critical mass media research responds to the call for theory-driven, complex views of health communication that are socially relevant and potentially useful to practitioners.

Understanding the Ideological Implications of Health Discourse for Identity and Social Power

Interpretive scholarship has prompted a turn from reductionist understandings of health and illness and highlighted the social production of knowledge. This work has stimulated attention to the role of ideology as shared sets of social beliefs, and critical perspectives have begun to investigate its role in shaping identity and the social relations of power that influence health and illness. We now describe work that connects ideology to identity construction and relationships of domination and resistance.

Constructing Identity

Interpretive/critical perspectives have brought attention to the ways that health discourses construct, reinforce, or resist social identities. Interpretive research views the self as dynamically constructed and identity as an ongoing communicative process rather than a fixed category or a variable that influences message "reception," an important revision of post-positivist assumptions (see related review by N. Young, 2007). We described identity issues in illness and disability research above; in this section, we discuss the politics of identity construction in health discourse.

Critical work draws attention to strategic and unintended identity construction in health social marketing campaigns and biomedical discourse. Lupton (1995) argued that campaigns typically represent the public as apathetic and in need of shocks and "stern warnings" (p. 115), such as AIDS campaigns that use fear appeals based around a discourse of punishment for sexual sins

and denial of pleasure. According to Lupton, campaigns draw on body image concerns, so, for example, overweight bodies are depicted as disgusting and out of control. Her textual analysis built the theoretical argument that the consumerist tenets of social marketing fail to apply to the ascetic and top-down approach of most illness prevention campaigns. Critical work in biomedical discourse similarly addresses embodiment as it describes relationships between diagnosis and identity. Nadesan's (2005) genealogy of autism examined how multiple historical and contemporary discourses (psychiatric, psychological, and biogenetic) have constituted autism as a diagnosable "disorder" and delimited therapeutic authorities and protocols. She described the implications for the autistic self, when diagnosis can both produce stigma but also reduce "responsibility" for behavior "problems" and investigated how high functioning autistics such as those with Asperger's inhabit, alter, and resist ascribed identities. Nadesan identified a theoretical challenge for the field in finding ways to address relationships among materiality/biology, culture, and identity, without reifying these complex concepts.

Health and biomedical discourse also reflects and reinforces social stereotypes about marginalized social groups. Paula Treichler (1987, 1999) illustrated how stereotypes of gay identity deeply influenced both public and biomedical discourse about the emerging AIDS epidemic and which then contributed greatly to the stigma associated with both homosexuality and HIV/AIDS.

Influencing Social Power Relations

Treichler's (1987) study makes clear that issues of identity and marginalization are intimately connected to the constitution and perpetuation of social power differentials. Critical/interpretive scholars have begun to address relationships among health discourse, power, and economic, gender, and racial hierarchies.

Critical perspectives that investigate ideology and identity in health promotion initiatives have described the social and economic interests that they privilege. In an early articulation, McKnight (1988) argued that lifestyle campaign messages themselves actually may be "unhealthy" for those who need political power to change their social circumstances. He asked, "Could it be that for those in greatest need, their health does not depend upon receiving messages? Could it be that their health depends upon controlling the microphone?" (p. 43). Follow-up has been somewhat slow but is emerging. Zoller (2003b) described how the seemingly value-neutral health promotion program at a workplace fitness center established norms for the body and employee identity that reinforced managerial values of hard work, self-denial, and self-control. These identity constructions actually promoted employee consent to occupational health hazards. More broadly, critical approaches demonstrate how the individualistic and scientific ideologies of the "new public health," with its emphasis on self-care, directly contradict the stated goals of

redressing inequality and promoting democratic participation (A. Peterson & Lupton, 2000).

In terms of medical hegemony, a wealth of interdisciplinary research describes the power of physicians, managed-care representatives, and pharmaceutical interests. Payer (1992) described how promotional discourses contribute to medical power and profits as they promote (over)treatment and (unnecessary) testing by "making you feel sick." Waitzkin (1991) detailed bias in physicians' talk with patients through critical analysis of actual transcripts of medical visits, finding that physicians reinforce dominant gender and class assumptions. Scholars exhibit growing interest in issues of communication, power, and economics in health care, including the ability to influence medical decision making and diagnosis, health policy, and prescription drug usage (Conrad & McIntush, 2003; Geist & Hardesty, 1992; Lammers & Geist, 1997; Stokes, 2005).

Feminist and cultural researchers have made great strides in specifying the roles of gender, sexuality, and ethnicity in organizing social power differentiation in the domain of health and communication. Though feminist research addresses multiple forms of oppression (K. A. Foss, S. K. Foss, & Griffin, 1999), it concentrates on how health discourses both reflect and construct gender roles (and are, therefore, both gender*ed* and gender*ing*). Feminist researchers have contributed to health communication by systematically focusing on health issues unique to women, including fertility, pregnancy and childbirth (Davis-Floyd, 1992; Treichler, 1990); cervical (Posner, 1991), ovarian (Sharf et al., 1996), uterine and breast health (Ellingson & Buzzanell, 1999; Kline, 2003) and menstruation and menopause (Gannon & Stevens, 1998). This work corrects the assumption that women's health can be understood through research based primarily on men's bodies and health experiences (Tavris, 1992) and challenges a history of women's marginalization in the biomedical sciences.

Theoretically, interpretive/critical scholars have shown how medical hegemony in Western cultures reflects and reinforces gender and racial hierarchies. As Barbara Ehrenreich and Deirdre English (1978) convincingly detailed, in Western societies, the socialization of women has been intimately tied to the hegemonic status of the medical institution and vice versa (see also Corea, 1985; Daly, 1990; Davis-Floyd, 1992; Dreifus, 1977; Hubbard, 1990; Jacobus, Keller, & Shuttleworth, 1990; Oakley, 1984; Ratcliff, 2002; Rothman, 1989; Vanderford & Smith, 1996). Thus, interpretive/critical research on women's health has elaborated broader theories of professionalization (legitimation of authority and medical hegemony) (Ehrenreich & English, 1978), the technological imperative of medical practices (Harter & Japp, 2001; Pineau, 2000), and the pathologizing and medicalization of normal body processes (Crawford, 1980; Zola, 1972).

Health discourses both reflect and construct gender roles. For instance, Lantz and Booth (1998) critiqued the mass media for suggesting that "it is those women who are behaving less traditionally (e.g., those who are delaying

childbearing or not having children, those who control their fertility with birth control pills, those women who drink alcohol, etc.) who are experiencing an increased risk of breast cancer" (p. 916) and are, therefore, to blame for the breast cancer epidemic. Arrington (2005) described how men's post-prostate cancer stories illustrated changes in their family roles, communication, and relationships. Interestingly, research about men's health often discusses how men's social roles are socially constructed in dialectal tension with the social construction of women's roles (Courtenay, 2000; Coyle & Morgan-Sykes, 1998; Lyons & Willott, 1999). For instance, myths of paternity have absolved men of responsibility for lifestyle choices that might cause fetal harm in contrast to cultural myths of maternity that blame women for fetal harm (Daniels & Parrott, 1996).

With increasing attention to queer theory in the broader discipline of communication (Yep, Lovaas, et al., 2003), we also note at least some research concerned with the health experiences of, if not the full range of "queer" individuals, at least gay men and lesbians (see also Harcourt, 2006; Northridge, 2001). Much of this research refers to gay men and HIV/AIDS (noted throughout this chapter, but also G. Brown & Maycock, 2005; De Moor, 2005; Farrell, 2006; Stone, 1999); however, some researchers have explored lesbian health care experiences (Chao, 2000; Feinberg, 2001; Stevens & Hall, 2002). Research related to sexuality often comments on how relevant discourses reinscribe heteronormative values (Braun, 2005) in ways that reinforce the stigma and "deviance" associated with gay, bisexual, transsexual (or queer[4]) identities. In sum, interpretive/critical research investigates the interrelationships of power and gender construction, contrasting with approaches that treat gender as a variable, which tend to focus on measuring (relatively stable) differences (Mumby, 1996).

A growing body of research also addresses how health-related ideologies reinforce racially and ethnically based health disparities, nationally and transnationally. For instance, cultural research situates marginalization and stigmatization of illnesses, such as AIDS, within existing power relations and a nexus of racial, national, sexual, and religious hierarchies (Petros, Airhihenbuwa, Simbayi, Ramlagan, & Brown, 2006). This research addresses the communicative processes that construct and maintain hegemony. A study by J. L. Johnson et al. (2004) of the experience of discriminatory medical treatment by South Asian immigrant women articulated *how* othering (as a communicative practice of constructing identities in opposition and magnifying differences) takes places in medical interactions through the use of essentialist, culturalist, and racialized medical explanations. Research describes how othering processes in health care further contribute to health disparities, such as the historical and sociopolitical issues that lead to African American distrust toward the biomedical community (Gamble, 1997; Harter, Stephens, & Japp, 2000). The culture-centered perspective explicitly links cultural constructions with structures of power. For instance, top-down health messages in a radio program in Nepal fail to respect cultural beliefs and reinscribe colonialist

assumptions, suggesting that family size should be determined by one's income (Dutta & Basnyat, in press).

Extant interpretive/critical work has challenged the basic theoretical orientation of health communication by moving from a representational view of communication as instrumental in achieving effectiveness to a constitutive view that envisions health, identities, and power relations as mutually constructed (for discussion, see Ford & Yep, 2003). This research addresses linkages between health experiences and social and economic power structures. Feminist and cultural research seeks understanding of unique social standpoints that elucidate multiple and overlapping forms of hegemony. Continued research should guard against essentialism, such as equating gender with (women's) sexual health or treating cultural groups as homogenous. This emerging body of work on identity and social power, which expands the goals of health communication research to include exposing and subverting systems of domination, merits further development. Much of this research also sheds light on the biases of the discipline as well, which we detail in the following section.

Deconstructing Biases in Dominant Approaches to Health Communication

Along with the recognition that health discourses are not politically neutral for individuals came attention to our own academic commitments and the ways that they are influenced by hegemonic power arrangements. Interpretive/critical research has promoted reflexivity regarding our own assumptions about health education and promotion. Interdisciplinary scholars like Lupton (1994c, 1995), Payer (1996), Gwyn (2002), Seale (2004b), and Airhihenbuwa and Obregon (2000) have investigated biases in health communication practices, including our own scholarly endeavors. Interpretive/critical researchers increasingly recognize and alter biases toward ideologies of objectivity and uncertainty, individualism and victim blaming, Western culture, and elite definitions of effectiveness.

Biased Methodological Assumptions

Interpretive/critical research deconstructs the values hidden in the "objective" voice of both medical and social sciences. One of the earliest works in the field to address health-related themes rhetorically, Martha Solomon (1985) conducted a Burkean analysis of medical reports in the Tuskegee Syphilis project to demonstrate the ideology of what is assumed to be objective medical reporting. The analysis showed how the very language of objectivity exposes a value that encourages the dehumanization of medical subjects, and how the goals of science can be driven by racist assumptions that contribute to human suffering. She illustrated the connection between medical communication

and its influence on actions (inactions) among health professionals and the larger public. This work implicates the presumption in our own research that medical decision-making comprises a neutral and scientific process that should be aided by better (clearer) communication. It also challenges the idea that objectivity constitutes either a possible or significant goal for communication researchers.

Additionally, as Babrow and Kline (2000) asserted, dominant views of objectivity and scientific medical knowledge have encouraged an "ideology of uncertainty reduction" in health communication (p. 1806). Babrow and Kline explained that "the ideology of uncertainty reduction is also attractive for its compatibility with the hoary biomedical or mechanistic paradigm" so that, "ultimately, the biomedical-mechanistic paradigm fosters the idea that uncertainty can—and should—be reduced and eradicated" (p. 1806). They used the mass mediated discourse of breast self-examination as an exemplar of the cultural construction of the ideology of uncertainty reduction and elaborate on the often problematic implications of these differences for health understandings. A study by Eisenberg et al. (2005) of emergency rooms supports this point, as the authors argued for the need for medical practitioners and scholars to better understand uncertainty in emergency medicine because it is central to this type of work. Thus, interpretive/critical research challenges views of communication borne of information theories that equate communication with objectivity and the reduction of uncertainty and encourages attention to the complexities of communicating in the face of multiple uncertainties.

Biased Approaches to Health and Illness

Research also underscores the bias toward individualistic definitions of health and illness and the failure of these definitions to account for the socio-political and even biological determinants of health (Crawford, 1977, 1980). Interpretive/critical communication researchers have challenged the ideology of victim blaming inherent in many dominant behavioral models of health promotion theory and practice. Kirkwood and Brown (1995) used rhetorical analysis to theorize about the latent messages of victim-blaming in disease prevention discourse perceived by already-diagnosed publics. Messages that focus on individual efforts to prevent disease contribute to assumptions that illness is an individual's fault. Zoller (2003a) found support for this claim as she noted that auto workers interpreted the lifestyle messages in their workplace health promotion program in ways that promoted blaming injured workers rather than changing workplace-generated sources of ill health, including stress, injury, and toxic exposure.

Kline's (1999) analysis of newspaper and magazine representations revealed that women were blamed for not "doing their part to reduce high breast cancer mortality statistics" and that they "established the locus of all reasons for refraining from the activity with the woman, and chastised these women for

failing to engage in the activity" (p. 135). As this research deconstructs the problems of individualistic, lifestyle discourses of public health and medicine, it clearly problematizes many of the dominant models of health promotion and medical interaction in the field of health communication itself. The Health Belief Model and the Theory of Reasoned Action, for example, focus on motivating individual behavior change, and they remain largely silent about addressing the socio-economic barriers that audiences may face in complying with such messages (Ashing-Giwa, 1999).

Biased Theories of Culture

Cultural research plays an important role in deconstructing both the presumption of objectivity and the focus on individualism. To begin, cultural research has indicated how apparently generalizable health promotion theories are culturally biased toward the U.S. middle-class context in which they are created. Dutta-Bergman (2005) used culture-centered and structural-centered approaches to critique dominant theories of health promotion for their individual, cognitive orientation. Dutta-Bergman illustrated how these theories overlook the role of the community in more collectivist cultures, the role of local meaning and customs, and material barriers to health. Airhihenbuwa and Obregon (2000) criticized the tendency to conflate "barrier" with "culture" when applying health promotion in contexts for which they were not created (p. 10). Kline's (2007) qualitative textual analysis of breast cancer education pamphlets designed for African American women revealed that pamphlets utilized rhetorical strategies that were consistent with dominant Western rationales. She argued that these rhetorical strategies undermined cultural sensitivity since they emphasized personal responsibility and empowerment contrary to African American spiritual and religious beliefs. Even research on interpersonal issues such as social support often stresses and assumes the communicative norms of European Americans. Addressing this gap, Yep, Reece, and Negron (2003) found that members in an AIDS support group for Asian Americans endorsed alternative treatments, paid greater attention to the "face needs" of members by avoiding conflict, and dealt with culturally based biases against homosexuality and HIV.

Critical-interpretive research facilitates a wider range of voices in health communication, deconstructing cultural biases and broadening the theoretical reach of the field to address those outside of dominant white, European groups, such as Asians, African Americans, Hispanic/Latino, and Native Americans (Airhihenbuwa, 1995; Aull & Lewis, 2004; Casas, Wagenheim, Banchero, & Menoza-Romero, 1994; J. L. Johnson et al., 2004; Lynch & Dubriwny, 2006; McLean, 1997; Vargas, 2000; Whaley, 1999; Yep, Reece, et al., 2003). The critique of cultural bias in many of these works calls us to go beyond "cultural sensitivity" responses because such approaches may promote static and stereotypical views of individuals and social groups. They may do so by failing to theorize culture as a network of meanings tied to sociopolitical processes and by ignoring individual

variation within groups (Dutta, 2007; J. L. Johnson et al., 2004). Owing to its in-depth engagement with cultural members, interpretive/critical research adds complexity to our understanding of cultural beliefs. This nuanced approach is evident in the Yep, Reese, et al. study described above, where they stated at the outset that the support group was marked by heterogeneity (multiple differences), hybridity (negotiation of dominant and traditional culture), and multiplicity (influenced by multiple power relationships).

Biased Definitions of Effectiveness

The concept of *effectiveness* in health communication often refers to gaining compliance with campaign or health provider messages (Witte, 1994). Commonly, communication strategies focus on promoting health by crafting interpersonal or mediated interventions that motivate individuals to engage in health-protective behaviors (see Cline, 2003; Salmon & Atkin, 2003). However, as Cline observed, the preceding critiques from interpretive/critical studies encourage us to significantly alter definitions of effectiveness by grounding practice-related research goals in the experiences and needs of those involved. For instance, Ellingson and Buzzanell (1999) examined women's narratives of breast cancer treatment to understand how these women defined and experienced satisfaction with physician communication. They contrasted these views with traditional communication satisfaction research, noting that these women's views of effectiveness included dialogic relationships and preferences for feminine communication styles.

In terms of campaign research, post-positivistic research tends to measure effectiveness in terms of behavior or attitudinal change, such as altered nutritional or sexual habits (Dutta-Bergman, 2005). Researchers have used grounded inquiry to investigate how different groups define effectiveness based on their own cultural and material circumstances (Cline, 2003). Critical scholars, in particular, recognize that interventions and effectiveness should be evaluated in part on their potential for facilitating agency among research participants themselves (Dutta-Bergman, 2004; Melkote, Muppidi, & Goswami, 2000) and emancipatory social change (McKnight, 1988; Zoller, 2005a). More work remains to be done in addressing biases in others' practices and our own. As Airhihenbuwa and Ludwig (1997) noted, even critical work in the tradition of Freire that promotes critical consciousness often focuses on the consciousness of the targeted rather than the interventionist.

Developing Context-sensitive Models of Health Promotion Communication

We have shared how interpretive/critical research has contributed to the deconstruction of biases in our presumptions and models. To move toward praxis, we describe how some interpretive/critical scholars have begun to develop context-

sensitive models of health promotion. Many of these alternative theories have arisen from scholars who address the role of health in the global south among marginalized groups and critique the lingering colonialist assumption of many Western campaigns. Other context-based research promotes participatory methodology for creating campaigns with marginalized groups, where the gaps between top-down approaches and local needs also are quite evident.

Culture-centered Models

Concerned that most health promotion programs are guided by the "Western so-called scientific culture" (p. 27), and based on his research in South Africa, Airhihenbuwa (1995) developed the PEN-3 model of communication to "offer a space within which cultural codes and meanings can be centralized in the development, implementation, and evaluation of health promotion programs" (p. 28). The model accounts for cultural identity, relationships, and expectations, and it conceives of cultural empowerment as a key health intervention objective. The model also emphasizes the need to consider cultural motivations and reward "positive" behaviors rather than focusing on "negative" (individualized) behaviors or benign behaviors indigenous to the group that some blame for failure to adopt recommendations (see also Airhihenbuwa & Obregon, 2000; Airhihenbuwa & Webster, 2004).

Dutta-Bergman (2004) articulated the culture-centered approach to health communication. The culture-centered approach treats culture as dynamically constitutive of health meanings, "with an emphasis on speaking from the margins, on building epistemologies from the margins, and on creating alternative discursive spaces for the conceptualization of health" (p. 1108). The perspective foregrounds agency by "acknowledging marginalized people's capacity to determine their own life course, model their own behaviors, and develop epistemologies based on self-understanding" (p. 1108). Clearly, this model radically reconceptualizes the role of the researcher in health campaigns, from creating messages to providing spaces for marginalized groups to articulate their own needs and formulate solutions (Dutta, 2007). The model differs sharply from the traditional, top-down approach of health campaign scholars.

Participatory Methodologies

A growing number of interpretive and critical studies have begun to adopt participatory research methods to improve the appropriateness and effectiveness of campaigns and health delivery and to promote more democratic models of health interventions (Harter et al., 2007; Melkote et al., 2000). Community organizers on the Warm Springs Indian Reservation chose health projects based on the needs of residents as articulated during dialogue and trust-building sessions (McLean, 1997). Even the increasing use of focus groups

demonstrates the growing awareness of the importance of understanding how audiences define problems and interpret promotional messages; for example, Bull, Cohen, Ortiz, and Evans (2002) engaged focus groups to develop a targeted media campaign to promote condom use among women. Scholars have also employed narratives as a participatory intervention. Workman (2001) gathered narratives from fraternity members about drinking alcohol and then distributed these local narratives on campus to change social norms and challenge dominant perceptions about binge-drinking.

Interpretive/critical research has helped to demonstrate the need for health promotion methodologies that involve dialogue and practical engagement with health campaign audiences in the formation of both the goals and methods of interventions, and it has promoted alternative, context-sensitive models. We look to the growth of rigorous assessment across studies with the growth of these methods.

Investigating Health Policymaking as a Communicative Process

Interpretive/critical research also expands the potential for health communication intervention by linking health discourse to health policymaking processes. In the early years, health communication scholars generally did not address policy as an element of health communication. Sharf (1999) discussed the absence of policy research as one of the most important oversights in the field, given its influence on public health. Though policy is by no means the sole province of interpretive/critical perspectives, these paradigms bring insight to the interpretation and influence of existing policies as well as the negotiation of new ones. Work addresses agenda setting, elite policy processes, and the experience of health policy.

Agenda Setting

A central concern among critical scholars involves understanding the ability of different groups to set public agendas and to frame debates. Interpretive and critical research examines how stakeholders frame issues as groups compete to define concerns as social problems as a way to advance particular responses and solutions. In doing so, it questions taken-for-granted assumptions about social participation in political debates, emphasizing meaning formation as well as expression.

Rhetorical analyses such as Perez and Dionisopoulos' (1995) study of the Surgeon General's report on AIDS illustrate the role of policy reports in setting public agendas such as Reagan's rhetorical management of the AIDS crisis. Dejong and Wallack (1999) criticized the discourse of the U.S. anti-drug media campaign for promoting simplistic messages against drug use in the face of its failure to promote drug treatment. Zoller (2005b) used feminist analysis

to examine how the language of the U.S. Public Health Service's *Healthy People 2000*, despite explicit attention to health disparity, guides public health policies in ways that may reinforce inequities among women (particularly minorities) by failing to prioritize their social and material circumstances in its "multi-causal web" approach to health (p. 179). These analyses demonstrate that policies hinge on rhetoric about health that always involves value-laden theories of disease causation and prioritization, which the public may presume are scientific rather than political decisions.

Law-making Processes

Conrad and McIntush (2003) provided a number of theories for understanding health care policy making as a process marked by complex interactions among rhetoric, ideology, and structure. They noted that functionalist presumptions of rationality and equitable participation in policymaking are problematic from a communication perspective. Their chapter illustrates the interdisciplinary nature of health policy research by drawing from organizational theories including "garbage can" approaches to decision-making, mobilization, and community-power debates. Conrad and Jodlowski (2008) also articulated the role of rhetoric in elites' ability to outflank the public in policymaking, using de Certeau's (1984) and Mann's (1986) theories of strategic action and outflanking/counteroutflanking. At the micro-level of interaction, textual analysis of public transcripts of Congressional testimony shows framing devices employed in unfolding communication during policy debates over nicotine (Murphy, 2001).

Health communication researchers help to demonstrate how health policy discourse is unique from other policy contexts. For instance, Sharf (2001) explained that the powerful influence of personal breast cancer narratives on legislators and other health policy leaders put breast cancer on the agenda, but this kind of funding often occurs at the expense of other health spending. Other unique issues include the privileging of "conservative medical-psychiatric and health bureaucratic solutions to policy 'problems'" (Hazelton, 1997, p. 88), and the promotion of "biofantasies"—mass-mediated stories that play up the medical benefits of genetic research—in deflecting public attention from systemic problems, social conditions, and the environment (A. Peterson, 2001).

Policy and Health Experiences

Critical perspectives, in particular, can address the power-laden contexts of policy making and their influence on the lived experience of different publics. Though not specifically oriented toward health communication, Gillespie's (2001) use of feminist and postmodern lenses to examine "asthma as a symbolic site of struggle over definitions of appropriate health care resource

utilization in the wake of Medicaid's move to managed care" (p. 98) illustrated the value of interpretive/critical policy research. She described how the disciplinary practices constituting managed care encourage patient self-care and responsibility. These expectations guiding physician communication about asthma failed to address material, class-based barriers (such as lack of control over living conditions, transportation, etc.) and social barriers (e.g., depression), leading to "non-compliance" classifications. She found that capitation also creates unrealistic bureaucratic barriers for marginalized groups. The project highlights the experience of lower-income patients in managing these policies, providing an important corrective to health communication that, along with the field at large, can be accused of focusing on issues of importance to middle-class audiences. It also redresses the problem of client-provider communication that concentrates on "patients" only while they are in the provider's office.

Growth in policy research is fundamental to the goals of emancipation central to critical research. Notably, eight years after Sharf's (1999) call for more policy research, researchers still need to build advocacy to improve health policies and the communicative processes that produce them.

Highlighting Possibilities of Resistance and Social Change at the Margins

We have discussed the role of interpretive/critical theories in facilitating social change by developing context-sensitive health promotion models and examining policy mechanisms. Additionally, by building theories about the political implications of health discourse, interpretive and critical researchers have begun to create space within the discipline for the study of resistance and social change among marginalized groups. The deconstruction of taken-for-granted assumptions about what counts as health (e.g., bio-medical) and how it should be achieved (e.g., physician compliance and lifestyle directives) creates the possibility of resisting dominant relations of power reinforced by those assumptions and altering social arrangements. Perhaps because of the relative lack of critical perspectives in health communication, much existing research into health-related resistance and social change comes from rhetoric, cultural studies, and other areas of communication. We now describe what health communication research contributes to this body of knowledge through a focus on agency and resistance as well as advocacy and activism.

Agency and Resistance

We have noted that, in contrast to the view of patients and health communication audiences as passive, interpretive/critical researchers have brought attention to their agency, particularly among marginalized groups (Dutta-Bergman, 2004; Geist Martin, Ray, & Sharf, 2003). Understanding resistance comprises a key part of this development. Previous researchers sometimes equated

"resistance" with a failure to comply with health directives (see, for example, Brashers, Haas, Klingle, & Neidig, 2000). Interpretive research sheds light on resistance as a means of facilitating autonomy and increased choice-making. For instance, Stivers' (2004) conversation analysis detailed parental resistance (both passive and active) to medical treatment recommendations for children as a normative, integral part of the clinical interaction. Thus, even pediatricians envision treatment conversations as negotiations. Though Stivers described this negotiation as problematic because parents often secure unnecessary antibiotics, interpretive/critical researchers are slowly overcoming the idea that resistance should be understood primarily as an irrational barrier to behavior change (see Sharf, 2005). For example, focus groups suggest that many audiences of direct-to-consumer marketing actively resist race-based pharmagenics, in contrast to popular fears about negative influences of genetic discourse on public opinion (Bates, Lynch, Bevan, & Condit, 2005). Zoller (2004) found that some manufacturing employees actively resisted the health promotion messages from their workplace recreation center by ignoring the advice, avoiding the center, and engaging in the proscribed behaviors. The critical lens conceptualizes these choices not as psychographic barriers but as reactions against authority and the disciplinary tone of health messages; thus, Zoller argued that employers should respond through more responsive, open, and participative promotion initiatives rather than alternate motivational messaging strategies.

Interpretive/critical research also highlights agency by promoting personal empowerment over the management of our health and illness. For instance, Sharf (1997) described how an online breast cancer discussion group empowered women by enhancing decision making and helping women to understand the experiences that they may face. Scholars increasingly examine community empowerment as a form of health promotion (see, for example, Ford & Yep, 2003; Harter, Scott, Novak, Leeman, & Morris, 2006).

Advocacy and Activism

Community empowerment is closely tied to health advocacy and activism. Interpretive/critical research brings particular attention to social change at the margins. Elwood, Dayton, and Richard (1996) observed HIV prevention outreach workers in Houston, Texas in the United States to understand the efficacy of street-level prevention work often focused on harm reduction. Using Burke's theory of identification, they conceptualized identity building as a communicative skill versus a demographic category, thereby facilitating a politically controversial but important health intervention among stigmatized groups.

Despite the key role that activists play in influencing the experience of health and illness, health communication research largely overlooked these often grassroots challenges to existing power relationships in health, focusing instead on the communication needs of established professionals. Interdisciplinary research in sociology and social movements describes how activists have

established public health infrastructures, challenged social stigmas associated with illness, advocated for patient roles in scientific research, and agitated for health policies (Zoller, 2005a). In communication, rhetoric and social movement research has helped to redress the lack of attention to activism by investigating health-related social movements such as the HIV/AIDS activism of groups like Act Up! (Christiansen & Hanson, 1996). These studies highlighted the communicative strategies of AIDS activists to reduce stigma associated with the disease, spur research into treatments, and promote accessibility to those treatments (Fabj & Sobnosky, 1995; Sobnosky & Hauser, 1999).

Critical-cultural research has begun to address how activists both work with and resist the scientific community. Wood, Hall, and Hasian (2008) investigated grassroots resistance surrounding the Human Genome Diversity Project (HGDP). Their study highlights activism among subaltern groups aimed at shaping the course of genetic policy. Rhetorical analysis reveals how activists question and seek to revise the HDGP, which is a seemingly straightforward attempt to accrue diverse genetic samples to create a more complete genetic map. These groups embed the discussion of genetic diversity within larger contexts of participation and control in science, racism, colonialism, and Western exploitation. Additionally, environmental communication research investigates environmental health activism, and this area presents a significant opportunity for interdisciplinary collaboration. For instance, some radical counter-public groups resist the individualistic and medical model accompanying National Breast Cancer Awareness Month by highlighting the environmental risks of breast cancer including industrial toxins (Pezzullo, 2003). Local communities and grassroots groups, often organized by women, contest environmental damage out of concern for apparent cancer and birth defect clusters, such as groups in the Texas-Mexico border area concerned with outbreaks of anencephaly (T. R. Peterson, 1997).

Interpretive/critical health communication theories can contribute to interdisciplinary research by describing the political consequences of how activists define health, describe illness causality, attribute responsibility, and depict social identities for social change (Zoller, 2005a). Additional work should address linkages between health communication and the interdisciplinary research focused on globalization and resistance (discussed by Pal & Dutta, this volume), given the influence of these policies on global health status (Zoller & Dutta, 2008) and the field's concerns with global health disparities.

LESSONS LEARNED AND FUTURE DIRECTIONS

One of our primary purposes was to build the case for defining and conceptualizing the theoretical contributions that interpretive/critical research makes on its terms, rather than to compare it against the criteria of replication, generalizability, and prediction. While a number of ways exist to articulate

the accomplishments of interpretive/critical research, our review suggests that interpretive/critical research addresses issues of health meanings; adds complexity to our understanding of health, health behaviors and identities; examines persuasion in health discourse from other points of view beside effectiveness; articulates linkages among communication and politics, policy, and social power; deconstructs taken-for-granted assumptions about health and illness and conceptualizing alternatives, and describes direct implications for practice. Given the highly interdisciplinary nature of the health communication research, the kinds of contributions identified in the chapter also apply to other areas of communication where interpretive/critical researchers also investigate meaning construction, build knowledge of communication and everyday experience, theorize the politics of identity construction and their relationship to social power, amplify marginalized voices, and develop systemic approaches to praxis.

Interpretive/critical researchers rely most often on qualitative inquiry but, more importantly, they embrace what can be learned uniquely through qualitative inquiry. For instance, the active participation of scholars in ethnographic inquiry gives us insight into what can be messy, embodied interaction in which body, mind, emotion and spirit interrelate in communicating about health. Rhetorical scholars delve into the latent meanings of public discourses, making sense of rhetorical style, artistry, hidden logics, and sociopolitical context. Critical cultural scholars attend to audience ability to negotiate meaning, positing more complex explanations than the linear or hypodermic models of the past.

We are encouraged by the growth of reflexivity in the reporting of interpretive/critical research. More work acknowledges the role of the authors in selecting what counts as data as well as how it is interpreted and written about. Scholars increasingly embrace the ethical commitments of humanistic research to address the broader political implications of our research.

Having articulated some of the positive contributions of interpretive/critical research, we turn now to some of the challenges that lie ahead. We identify areas for further development, focusing on the need for stronger articulation of the value of interpretive/critical work, greater theoretical range, and more direct engagement with praxis.

Validation

Communication scholarship would benefit from stronger and more consistent framing of the overall contributions of interpretive/critical studies, especially in the area of health communication. Some studies continue to describe interpretive methods as pre-scientific, suggesting that findings must be validated using quantitative measures (though we recognize that these choices could potentially reflect editorial requests). Nonetheless, when authors describe limitations such as smaller samples (thereby reducing generalization) (e.g.,

Clarke, 1999) or a lack of operationalization (thereby reducing replicability), they implicitly apply scientific criteria rather than the assessment criteria appropriate for interpretive/critical research. When Bull et al. (2002) reported their focus groups with women (in which the participants talked about the lived experience of condom use and negotiation to guide the development of condom promotion campaigns), they presented the idea that every campaign may need to do similar audience research as a limitation. The improvement of health campaigns through interpretive audience research could have been heralded as a central finding of the study, rather than a limitation. Dillard et al. (2004) limited the significance of their qualitative analysis of communication surrounding newborn cystic fibrosis screening by describing it as a "descriptive foundation for future research" (p. 195). Some doctor-patient researchers acknowledge the contributions of qualitative research to understanding how communication develops in a contextualized way in interactions and observe need for integration between quantitative and qualitative research (Roter & McNeilis, 2003). However, others continue to frame qualitative research as a hypothesis generator (J. B. Brown et al., 2003).

Theoretical Range

In addition to using validity criteria, interpretive/critical research could more incisively frame theoretical contributions by explicitly tracing the implications of local practices over time and across contexts. Doing so would facilitate broader explanations that account for individual and cultural differentiation and guide practice. As we mentioned in the introduction, this suggestion does not differ substantially from calls for more theory-driven work in post-positivistic research. However, potentially, the use of hypotheses may lead researchers to more closely align their studies with previous scholarship in the area than research with concepts grounded in local contexts. Interpretive researchers need to be vigilant about drawing linkages across individual interpretive/critical analyses of various topics (e.g., breast cancer, tobacco use, diet, and exercise), contexts (e.g., interpersonal, social support, public discourse), and methodologies (e.g., ethnographic, rhetorical, critical cultural). We might ask, for example, what are the larger issues guiding the theory and application of audience research as a basis for developing campaigns? What do we learn across studies about audience interpretations and enactments of different types of health promotion campaigns? How can we bring research together theoretically to discuss the meaning of health and illness? How do individual studies inform our theories of power and resistance in health? Often, this sort of synthesis happens only in periodic review articles or books such as the *Handbook of Health Communication* (Thompson, Dorsey, Miller, & Parrott, 2003). Some of these results likely emerge in the forms of typologies, models, and schemas, too frequently discounted as theorizing. Yet, adopting contextual research means recognizing a broader array of theoretical advancements than

just prediction, and forms of explanation may include arguments, comparisons, and conceptual development.

Interpretive/critical research that analyzes data in terms of emergent "themes" (usually described as grounded or thematic analysis), in particular, must articulate its theoretical import in stronger terms. Beck et al. (2004) detailed publication patterns in health communication—location of publication, topics, and methodologies. According to their assessment, 55% of the articles that reported their methods described using thematic analysis versus 27% using multivariate analysis. We should link individual thematic analyses to larger sociocultural processes of meaning and health communication theorizing. When we examine research into topics such as college drinking stories (Workman, 2001), defenses against anti-smoking messages (DeSantis, 2002), or condom-usage (Bull et al., 2002), we find useful insights into the contextual factors that influence how recipients interpret and respond to health promotion campaigns. They address the barriers to adopting health-promoting behavior, thereby promoting more appropriate and targeted campaigns. The field can investigate such themes for other audiences and contexts, thereby providing a fuller picture of the interpretive processes and contextual (and material) factors that should guide intervention. Grounded research can build theorizing as well as studies that adopt explicit theoretical lenses to the degree that individual studies speak to the larger research dialogue about the issues under discussion.

We also can promote more theory development by drawing from a greater range of existing perspectives and theories. In our review, we observed that narrative theory, the theory of Problematic Integration (Babrow, 1992, 2001), and the culture-centered approach have received a good deal of attention. Yet, for example, significant room remains for development of dialogic perspectives that help to focus on the role of language and the co-construction of meaning in health contexts. Likewise, though we occasionally found references to specific rhetorical theories (e.g., discussion of Burke's "representative anecdote" in Harter & Japp, 2001), the long tradition of rhetorical studies has generated numerous theories that could inform and/or be informed by interpretive/critical research in health communication. Individual research projects need to articulate explicitly theoretical frameworks rather than merely allude to relevant perspectives and theory (as in the mass media research mentioned above that invoked the concept of preferred reading without overtly discussing the theory). Doing so would facilitate interpretive/critical health communication research contributions to the broader discipline.

The theoretical range of health communication research also would be enhanced by more explicitly critical research, especially in terms of cultural, subaltern, queer, and postmodern theories. This call is quite common across the discipline (German, 1995; Lannaman, 1992; Mumby, 1993). Despite recent research that explores issues of ideology and hegemony, health communication could benefit from continued work that elaborates how the social construction

of health and illness relates to issues of power, politics, and resistance—and how those relate to individual and cultural identity. Future research should continue to connect the individual experience of health and illness with larger material and symbolic systems. Such investigations add complexity to our understanding of human agency among patients, clients, media audiences, research participants, and campaign targets. Critical perspectives can shed light on the potential paradoxes of resistance in health contexts given the gulf between personal/embodied and professional knowledge, where nonconformity can produce either better or worse health outcomes. Additionally, attention to other outcomes such as autonomy, voice, participation, and social change would add complexity to understanding of health and resistance.

Interpretive/critical scholars have made great strides in fostering interdisciplinary connections, especially with sociology, medicine, public health, and nursing. A great deal of cross-pollination among interpretive/critical scholars in sub-disciplines of communication exists as well, including a significant amount of work in organizational and public communication. As this trend continues, we encourage greater collaboration between health communication and some areas with which we have had little dialogue, such as environmental communication and social movements. Working with these areas would broaden our conception of what constitutes health by better linking human health and the natural world and what constitutes health communication practice by investigating activism along with more traditional areas of communication. Moreover, areas of the discipline with strong contributions to health communication (such as technology and interpersonal studies) are rarely investigated using rhetorical analysis or ethnographic methods.

Theory and Praxis

We have described the evolution of interpretive/critical research concerned with the implications of relevant theorizing for the practice of health communication (i.e., praxis as theoretically informed social change). Deetz (2001) argued that the primary role of theorizing should be to enable useful responses. In this vein, as researchers uncover communication conceptions and problems as defined by everyday people (Craig, 2007), they should not only articulate what useful responses would look like (as many do) but investigate the actual processes through which alternative forms of practice can be put into place.

One of the most explicit linkages between interpretive research approaches and health communication practice pertains to the development of participatory models of health promotion and medical interaction. Interpretive/critical research, using multiple methodologies, investigates the potential of such models for practical intervention and for revising the guiding assumptions of some of the existing models of health communication (e.g., the Health Belief Model). Culture-centered research demands reflexivity, so that the voices of the marginalized are not merely co-opted to increase the effectiveness

of professionals' existing goals but actually transform our understanding of what constitutes good health communication. The field requires additional investigation of participants' lived experience of participation, fostering a depth of insight into the challenges of including patients, audiences, and communities in substantive decision-making. These challenges are multiplied as we begin to address participatory systems that promote collaboration across economic, gender, ethnic, and national lines.

We also described growing interest in the role of communication in constituting, applying, and challenging health policy, though we noted that much more work remains to be done in this area. Moving forward, the connections between a broad array of research contexts and health policy can be made more explicit. We must give greater attention to changing health policy as an element of health communication practice, along with understanding the implications of these changes for health communication theorizing. Furthermore, reducing health inequities constitutes a key goal for many health communication researchers. Given the massive social change wrought by economic and cultural forms of globalization, investigating the relationships among international trade policy, health status, and social discourses about health is crucial for contemporary health communication.

In closing, we acknowledge that the "disciplinary" work of a chapter like this one comprises an act of construction and interpretation on the part of the authors. Reviews such as this chapter are disciplinary in the sense of drawing and defining disciplinary boundaries, and they may also "discipline" (in the Foucaultian sense, see Foucault, 1979) the field in terms of delimiting what counts as interpretive, cultural, and critical research and, indeed, a "contribution." Yet, we believe that continued dialogue across methodological and metatheoretical approaches about the mutual benefits of our research is necessary to the development of health communication research. Our analysis clearly shows that the flagship journals *Health Communication* and *Journal of Health Communication: International Perspectives* have become good places for such dialogue, given that both include work from across the spectrum of philosophies and methodologies. We hope, then, that readers take this chapter as an invitation for continued conversation about the growth and development of multiple theoretical perspectives in health communication, rather than as a definitive statement on the field.

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NOTES

1. There has yet to be a broader description and assessment of the contributions of interpretive/critical research to theory and practice in health communication. A number of books (e.g., Elwood, 1999; Gwyn, 2002; Seale, 2004a, 2004b; Tulloch & Lupton, 1997), handbooks and edited volumes (Parrott & Condit, 1996; Thompson et al., 2003), and textbooks (Beck, 2001; duPre, 2000; Geist Martin et al., 2003; Jackson & Duffy, 1998; Kar & Alcalay, 2001) synthesize the studies in various domains of health communication; given their comprehensive examination of specific topics, these texts increasingly reference interpretive/critical analyses (and demonstrate for the attentive reader, the contributions of interpretive/critical research).
2. For instance, focus groups are one means of acquiring data. Many methods textbooks consider this a qualitative research method (e.g., Keyton, 2006), and one might erroneously assume that this positions focus group research within the interpretive/critical paradigm; yet, scholars who gather their data using focus groups can employ either quantitative or qualitative methods of analysis.
3. The methodological boundaries between interpretive/critical and quantitative content analyses often blur in the pursuit of descriptive and explanatory research (Kline, 2003).
4. The concept of "queer" allows us to go beyond simplified notions of homosexuality that, in effect, dichotomize sexuality along the lines of a heteronormative masculine/feminine dichotomy.

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