Chapter 1

Theoretical foundations

Interpretive, critical, and cultural approaches to health communication

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In some ways, the field of "health communication" may appear to address a relatively straightforward set of goals and concerns. For example, health provider communication may be studied to improve patient compliance with health directives, such as completing prescriptions or reducing cholesterol intake. Public health communication interventions may be designed to bring about some desired health improvement goal in a target audience, and the results measured in terms of their effectiveness in achieving change. Certainly, these health initiatives are ubiquitous: African Americans in the rural South are encouraged to take five or more servings of fruits and vegetables to reduce their cancer risks, people are encouraged not to smoke, workplaces cajole employees to exercise so as to lower absenteeism and reduce insurance rates. In these efforts, communication involves methods of persuasion (such as motivation, fear, encouragement) that can be measured in terms of effectiveness.

Of course, achieving these goals is not straightforward. Health communication research shows us that communication is not a "magic bullet" that can create change. Health messages, whether mass mediated or interpersonal, must engage with the complexities of human needs, motivations, and priorities. Indeed, health communicators are working to create interventions more sensitive to these issues (Edgar et al., 2003).

However, there are still more complexities in the communicative endeavors described above beyond the challenge of effective behavior change. Each of these goals relies on a particular approach to the meaning of health, making assumptions about how health can be achieved and who has the authority to instruct others. The ways in which intervention objectives are determined and evaluative criteria are configured are predicated upon certain assumptions that are taken for granted about what it means to be healthy and what constitutes health (Dutta, in press; Dutta & Basu, 2007; Dutta-Bergman, 2004b). The projects themselves may come into question when contextually embedded in social and political systems. What counts as illness, whose therapies are recommended, and who has the means to pay for prescriptions? Why is fruit and vegetable consumption addressed as the predominant means for preventing cancer? Why does management promote exercise when their

companies have high rates of occupational illness and accidents? Each of these questions involves broadening our conception of communication to address the social construction of health and illness and the underlying dimensions of power that are central to health communication. In this book, we would like to add multiple layers of complexity to our understanding of relationships between health and meaning. By highlighting the emergence of interpretive, critical, and cultural research perspectives, chapters in this book will demonstrate the utility of asking an array of questions about health communication, including: what meanings of health are operating in a particular circumstance, how have those meanings been culturally constructed, whose meanings are circulating, and with what material and symbolic consequences?

In organizing this introductory chapter to the book, we decided to begin by examining what it means to study health communication. What is health communication? What unites the different approaches to the study of health communication? What are some of the common threads that join these different approaches? After setting up the scope of health communication as a field of inquiry, we shift our attention to theory. What constitutes a theory and what are the different approaches to theory building? What criteria shall we as students and scholars of health communication use in evaluating these different theories, and how do these criteria vary based on the approach we take toward the study of health communication? Our introductory discussion of theory will lay out the foundations for discussing the post-positivistic, interpretive, critical, and cultural approaches to health communication. After setting up each of these approaches, we compare and contrast them and provide exemplars of each in the study of health communication. Following the framework proposed by Babrow and Mattson (2003), we lay out the dialectical tensions that are inherent in the different approaches. We conclude our chapter by discussing the contributions of interpretive, critical, and cultural approaches and previewing the chapters to follow.

The discipline

In the introduction to the *Handbook of Health Communication*, Teresa Thompson (2003) points out that the field of health communication has grown dramatically in the last twenty-five years. As she notes, the field started with the creation of the Health Communication Division of the International Communication Association in 1975, and subsequently became a division under the same name at the National Communication Association in 1985. The flagship journal of the field, *Health Communication*, was started in 1989, devoted specifically to the coverage of research focused on the study of communication in health care. In her review of the field, Thompson notes that the field has grown substantively from its early years not only in terms of the amount of research being conducted, but also in the growth of its scope. Whereas the early years of health communication scholarship focused on the

interpersonal aspects of health communication, current research in health communication encompasses (a) organizational issues in health communication, (b) community-based aspects of health communication, and (c) popular media issues and campaigns in the context of public health and medicine. We also are beginning to see greater attention to cultural and policy levels of analysis.

Furthermore, we are seeing a growth in the variety of perspectives applied in health communication research. Whereas most of the early research approached the field from a post-positivistic lens, an increasing body of research has started addressing interpretive, critical, and cultural issues in health communication scholarship (Zoller & Kline, 2008). The popularity of these alternative approaches to the study of health communication is witnessed in the growing number of articles in field journals such as *Health Communication*, *Journal of Applied Communication Research*, and *Journal of Health Communication* that approach the study of health communication from these perspectives. One of the goals of this book is to highlight and showcase this increasingly important body of scholarship. As we do so, we hope to provide a launching pad for the student and the scholar in health communication who is interested in exploring these perspectives, as well as to demonstrate their utility to health scholars in disciplines such as sociology, psychology, and anthropology. This book features the works of scholars who embrace the interpretive, critical, and cultural frameworks as ways of understanding, explaining, and engaging with health communication processes and phenomena.

Whereas some of these approaches presented in the book emphasize in-depth understanding of health constructions, others explicitly focus on raising questions of social change. Most of the contributors employ qualitative methods, reflecting current trends in interpretive, cultural, and critical work in the field. Indeed, this predominance of qualitative methods may suggest the need for developing more quantitative approaches to health communication that ask critical questions and seek to engage in transformative politics.

What does it mean to study health communication?

Health communication refers to the array of communication processes and messages that are constituted around health issues. Scholarship in the field may be categorized into two broad categories based on its emphasis: the process-based perspective and the message-based perspective. The process-based approach to health communication explores the ways in which health meanings are constituted, interpreted, and circulated, investigating processes of symbolic interaction and structuration as they relate to health. The message-based perspective is concerned with the creation of effective messages about health, and it attempts to address strategies for creating effective communication that would accomplish the goals of the involved stakeholders. Of course, all of this begs the question of what constitutes health, but we

would argue that this foundational question is one that must be situated in light of particular contexts.

Elements of health communication scholarship

Despite the wide variety of paradigmatic approaches to the study of health communication that we will discuss, there are certain underlying principles that run through the various areas and levels of health communication scholarship. One of the salient features of this communication research is its commitment to praxis. Praxis encompasses the ways in which health communication scholarship comes to be enacted in the world. In this sense, health communication researchers examine the practice of health communication, and are concerned with the applications through which the study of health messages, meanings, and processes can inform the practice of health communication (Thompson, 2003). Studies in the field explore the possibilities of developing meaningful applications that are humane, effective, and responsive to the health needs of individuals, groups, and communities. Although scholars might disagree on what comes to constitute humane, effective, and meaningful communication, the field nevertheless is committed to the possibilities of developing meaningful applications.

The commitment to the examination of communication messages and processes in health settings also suggests that health communication scholars "get dirty" and immerse themselves in the field. Therefore, most health communication scholarship takes place in the context of physician–patient interactions, workplace health interventions, media outlets, community coalition building to create health infrastructures, and other applied situations. Sub-disciplinary journals such as *Health Communication* and the *Journal of Health Communication* attest to the engagement of health communication scholarship in "real world" settings, exemplifying research that typically takes place outside the realm of the typical convenience sample of classroom subjects that are overrepresented in much communication scholarship.

Yet another common feature of health communication scholarship is its interdisciplinary nature. The complex nature of health communication problems calls for the need to engage with theories and methods spanning across (a) various sub-disciplines of communication, and (b) various other disciplines beyond communication. For instance, scholars studying communication patterns in the physician–patient relationship not only need to engage interpersonal communication scholarship, but also need to interact with bodies of knowledge from medicine, nursing, medical anthropology, and medical sociology that engage with the question of the physician–patient relationship. Similarly, scholars examining the role of health policies in creating certain communication outcomes ought to engage with economists, sociologists, and others in order to develop a sophisticated understanding of health communication phenomena.

Finally, the field of health communication is dynamic, thus calling for continuous movement in the theories and methodologies that are applied in studying the health communication messages and processes. The continuously shifting terrain of health care today calls for constant updating of the ways in which we come to understand and study health communication phenomena. For example, present-day health communication scholars ought to understand the existence of health communication at the intersections of technology and globalization, two key trends in the current social configuration of the world that continue to profoundly influence our understanding of health and the ways in which it has come to be constituted in the world. Health communication theorizing is in a state of continual flux, necessitating that we revisit old theories, offer new ones, and continually revise the knowledge that has come to constitute the field.

Theoretical perspectives in health communication: dominant and emerging perspectives

Broadly speaking, the study of health communication may be grouped into one of the four following approaches: post-positivistic, interpretive, critical, or cultural studies. The dominant approach in health communication is the post-positivistic, with an emphasis on improving a variety of health outcomes as outlined by the biomedical model (Dutta, in press). The field, however, has witnessed an increasing trend toward the incorporation of interpretive approaches that emphasize health meanings and narratives, critical approaches that raise questions of power and control, and cultural studies that situate critical questions in cultural contexts (Zoller & Kline, 2008). It is worth pointing out at the onset that although this categorization scheme is offered as a way of labeling and understanding the different approaches to heath communication, it surely is not our goal to limit the scope of current health communication scholarship within these distinctly defined categories.

The post-positivistic approach is concerned with explaining, controlling, and predicting various levels of health outcomes by investigating the roles of communicative, social, and psychological variables. This line of research has typically been concerned with the identification of constructs, operationalization, measurement, and prediction of health-related communication constructs. For instance, the post-positivistic line of research on communication competence in health settings operationalizes what it means to be a competent communicator, measures communication competence, examines the effects of competence on heath outcomes and suggests communication skills for improving the communication competence in the population (Makoul et al., 1995). Similarly, the post-positivistic research on health campaigns focuses on identifying variables such as perceived benefits and barriers to action in order to develop effective health interventions. Ultimately, the goal of this line of scholarship is to create effective health communication solutions to

tackle problems addressed typically at the individual level (Murray-Johnson & Witte, 2003).

Much of the extant health communication research may be categorized under the post-positivistic paradigm, and has primarily focused on the roles of effective messaging strategies in health communication settings (social support systems, provider–patient interactions, health campaigns, health organizations, and media systems). This research focuses on identifying communication variables that influence health outcomes.

Interpretive, critical, and cultural studies approaches to health communication tend to be thought of as "alternative" because of the dominance of post-positivistic approaches (Zoller & Kline, 2008). In using the term "alternative," we realize that what is alternative can become dominant as discursive spaces of scholarship shift terrains and as the power structures within and across institutional systems change. The publication of this book and the increasing popularity of interpretive, critical, and cultural studies in health communication attest to the shifting mood in the field (Beck et al., 2004).

The interpretive approach to health communication emphasizes the construction of meanings related to health and medicine. Drawing from the theoretical traditions of hermeneutics, phenomenology, ethnomethodology, and symbolic interactionism among others (Lindlof & Taylor, 2002), interpretive theorists seek to understand how meaning is constituted and contested through interaction. Scholars applying the interpretive approach to health communication typically engage in documenting detailed descriptions of health meanings and the processes through which they are constructed and enacted, using a variety of techniques such as in-depth interviews, focus groups, participant observations, textual and rhetorical analysis, and ethnographies (Sharf & Vandeford, 2003; Geist & Dreyer, 1993; Ellingson, 2005). Most of these approaches are qualitative in nature, and emphasize contextually located accounts rather than generalizable explanations that predict health behaviors and outcomes. This qualitative approach allows for understanding the embodied performance of health and illness, as well as issues of textual style and artistry that are difficult to capture quantitatively. Increasingly, health communication scholars are adopting narrative perspectives, focusing on the role of stories in narrating health and illness experiences. The growth of this perspective is evident in the publishing of the edited book, *Narratives, Health, and Healing: Communication Theory, Research, and Practice* (Harter et al., 2005), which investigates the "murky, cluttered, and complicated interrelationships" addressed by narrative (p. 8).

Critical approaches emphasize understanding the role of health communication in constructing and reinforcing dominant power relationships, and in simultaneously marginalizing certain sectors of society. How do communication practices in health settings serve the status quo? How are the interests of the underprivileged sectors of social systems represented in the discursive space of health communication theories and applications? Critical

theorists in communication may be influenced by the same hermeneutic, phenomenological, and rhetorical perspectives as interpretive scholars, but also draw critical concepts from a number of sources. These sources include the neo-Marxist perspectives of the Frankfurt School, Antonio Gramsci, and Stuart Hall (Mumby, 1988), as well as what may be considered postmodern research derived from scholars such as Foucault and Derrida (Lupton, 1994; Waitzkin, 1991). Other branches include postcolonial theory (Spivak, 1999), feminist studies (Dow & Condit, 2005) and queer theory (Yep et al., 2003). Because of their explicit interest in issues of social justice, critical scholars studying health communication campaigns, for example, suggest that such campaigns contribute to the marginalization of the lower socioeconomic segments of society by shifting the responsibility of health on the individual, and obscuring issues of structural change that would address health inequities and disparities (Dutta-Bergman, 2005; Lupton, 1995; McKnight, 1988; Zoller, 2003a). Furthermore, the critical approach draws our attention to ideologies, "the interlocking set of ideas and doctrines that form the distinctive perspective of a social group" (Waitzkin, 1991, p. 12), which justify and reinforce capitalist relations as well as racial and gender inequalities related to health and health outcomes (Ellingson & Buzzanell, 1999; Gillespie, 2001; Waitzkin, 1991). Some critical scholars explore the intersections of health care and market forces with the goal of understanding the ways in which market logic undermines possibilities of structural health programs that would benefit marginalized communities (Conrad & McIntush, 2003; Gillespie, 2001; Waitzkin, 1983). Scholars investigating the constitution of health in the realm of national and global policies may interrogate health-care policies, and draw the interconnections between such policies and the material conditions of marginalization in the underserved sectors of the globe (Melkote et al., 2000). Critical perspectives are interested in hegemony as a relationship of consent between dominant and subordinate groups. However, hegemony is understood as a dialectical relationship of control and resistance (Gramsci, 1971; Mumby, 1997), so that critical perspectives also give attention to agency among marginalized groups by investigating the potential for nonconformity, resistance, and transformation (Lupton, 1995; Sharf, 1997; Zoller, 2005a).

The cultural studies approach emphasizes the culturally situated nature of health communication interactions and processes, and locates culture in the realm of structure and power (Dutta-Bergman, 2004a). In exploring the culturally constituted nature of health and in connecting the discussions of culture with issues of structure and power, the cultural studies approach provides a bridge between the interpretive and critical approaches. On one hand, it demonstrates commitment to the interpretive paradigm by emphasizing the local contexts within which health meanings are constituted; on the other hand, it shares commonalities with the critical tradition by emphasizing questions of power and the ways in which such questions of power shape the socially constructed nature of discourse (Airhihenbuwa et al., 2000). Cultural

studies emphasize "deconstructing the apparent 'naturalness' of the way culture is understood" (Lupton, 1994, p. 16). Often focused on how mass media influence society through the production of knowledge, the cultural studies approach also draws attention to the way that social structures are constituted at macro and micro levels. Furthermore, it creates openings for examining the ways in which agency is played out within the locally situated contexts (Dutta-Bergman 2004a). Culture here is dynamic and transformative, constituted through the locally situated meanings that are co-constructed in the realm of social structures (Airhihenbuwa, 1995; Dutta, in press).

The rise in interpretive, critical, and cultural approaches in the field necessitates additional platforms for academic exchanges, debates, and collaborations that involve these emerging approaches to the study of health communication. We embarked on this project of putting together a book that would highlight some of the best scholarship in these areas with the goal of providing a theoretical and methodological framework for scholars interested in these approaches, and documenting exemplars that illustrate how health communication scholars can engage in interpretive, critical, and cultural studies projects. We believe that the proliferation of these approaches to the study of health communication is a sign of healthy growth of the discipline, which opens up avenues for building the study of health communication processes and messages in ways that have hitherto been unexplored. In the next section, we situate this growth within the historical development of the field.

Historical developments

The early studies of health communication examined interpersonal issues such as physician–patient relationship and sought to measure outcomes with the goal of identifying skills-building exercises to train physicians and patients (Cegala & Broz, 2003). This line of work was complemented by a growth in health communication studies that sought to measure and examine the effectiveness of health prevention messages (Witte, 1994). What was common to both of these areas of study in health communication was the emphasis on understanding universal characteristics that might be generalized to the population, and the development of predictions based on systematic observations of certain health communication phenomena.

Post-positivism employs mostly quantitative research. This research focused on behavior change in both doctor–patient communication and health campaign research. Indeed, Burgoon (1995) went so far as to suggest that in the medical context, "The only models (statistical) that make any sense are probit or logistical regression procedures with 'Dead/Not Dead' as the prime dependent measurement" (p. 3). In campaign research, scholars emphasized the goal of gaining compliance from "targets" (Burgoon, 1995; Freimuth et al., 1993; Rogers, 1996). For instance, Scherer and Juanillo (1992) described the responsibilities of public health communicators as informing the public of risk,

training them with skills for "more healthful lifestyles" and persuading them to "assume more effective responsibility for maintaining their own health" (p. 313).

Witte (1994) argued unapologetically that health communication involves manipulating the public into behavior change. "Manipulation is not a popular word, yet it is really a major part of what health promotion and disease prevention is all about. Broadly defined, to manipulate or persuade means to influence people into doing what we want them to do" (p. 285). The focus on creating behavior change rests upon a relatively linear notion of communication that gives less attention to the role of the audience in giving meaning and embodiment to health messages. These models left little room for investigating the cultural and political implications of discourse such as HIV or substance abuse prevention.

The idea of manipulation invokes paternalistic attitudes. Rogers (1996) claimed that "The main independent variables of study in health communication research are usually of unquestioned good" and these include "HIV/AIDS prevention, substance abuse prevention and early treatment" (p. 18). Although reducing and preventing illness is generally positive, researchers should be careful not to assume that they know what is best for people. Paternalistic attitudes deflect the potential for critique of the researcher's goals and methods, which is important given the constantly changing landscape of medical and health-related knowledge and the complexity of experience.

Scholars began to comment on the limitations of this orthodoxy in the late 1980s and early 1990s, starting a conversation that would introduce alternative approaches to the study of health communication. These approaches were more meaning-focused, including interpretive, critical, and cultural perspectives. For example, McKnight (1988) questioned the emphasis on medical communication as a primary source of good health, and argued that health communication scholars should work toward empowering the disenfranchised as the key to improving health. Sharf (1990) introduced a rhetorical perspective for understanding physician–patient communication. Geist and Dreyer (1993) critiqued dominant approaches to doctor–patient communication, introducing dialogue as a theoretical lens for re-conceptualizing medical communication. Zook (1994) described a more holistic approach to defining health, calling for attention to the embodied experience of health.

Deborah Lupton (1994) called for work that focuses "attention on discourse and the ways that the use of language in the medical setting acts to perpetuate the interests of some groups over others" (p. 60). Lupton's book *The Imperative of Health* (1995) applied a critical perspective to the study of health campaigns, interrogating how dominant values are encoded in health messages with important implications for health, social identity, and material resources. During this time period, Airhihenbuwa (1995) also introduced a cultural perspective and critiqued the Western paradigm that guides health interventions. Ray's (1996) volume on disenfranchisement brought attention to the

role of marginalization in health status. As a result of this early work, interest in issues of meaning, culture, and even power are becoming more central to health communication research.

We are now seeing exciting growth in the development of interpretive, critical, and cultural perspectives in health communication (for instance Ellingson, 2005; Geist-Martin, Ray, & Sharf, 2003; Harter, Japp & Beck, 2005; Kline, 1999). We believe the growth and development of these perspectives represents a positive trend for the field. Indeed, we see this book as a celebration of the growth of this scholarship in health communication and as a way to share its theoretical and practical value with scholars working in the communication and health disciplines. We also see the need to evaluate existing research and theory in the area in order to help chart new territory that can foster and shape research agendas over the coming years. Thus this book presents the state of existing research and, we hope, offers insights into the potential of interpretive, critical, and cultural research to contribute to both the research and the practice of health communication. Ultimately, we hope that this book will provide not only a theoretical entry point for scholars interested in the study of health communication, but also a pragmatic point of entry into the practice of health communication.

Defining health communication theory

In order to describe theoretical contributions of "alternative" approaches, we must first revisit how theory building itself is seen differently by various research perspectives, and explain how we conceptualize the intellectual commitments of what we call interpretive, critical, and cultural perspectives. In the next few sections, we describe how theories are built in each of these domains. As we describe the theoretical underpinnings of various research traditions in health communication, we want to avoid making overly rigid distinctions that would fail to note how these traditions may overlap and complement each other, and avoid underplaying significant areas of conflict and difference. As outlined earlier, each of these approaches are founded upon certain tensions with the other approaches to the study of health communication. Although these tensions at times indicate opposite ends of a spectrum, it is also worthwhile pointing out that they exist on a continuum.

Research in communication is often divided into "Worldview I" and "Worldview II" perspectives, referring to scientific/positivistic/post-positivistic research, and interpretive/humanistic research respectively. Consistent with the discussions of Craig (1999) and Babrow & Mattson (2003), we suggest that the different approaches to health communication are founded upon the dialectical tensions of materiality/social construction, universal/specific, and social change/status quo. The dialectical tension of materiality versus social construction focuses on the ways in which health communication scholarship conceptualizes the nature of communication. Whereas perspectives drawing

upon materiality emphasize the material basis of communicative phenomena, the social construction approach focuses on the ways in which communicative meanings are constituted through interactions and exchanges. The tension between the universal and specific aspects of health communication processes touches upon the scope of health communication theorizing, and the degree to which the goals of research are to generalize findings across cases or to understand the role of the local context. The social change–status quo tension in health communication scholarship is built around the goals and objectives of the scholarly enterprise, based on the degree to which research seeks to understand and reinforce the status quo or seeks to understand and bring about changes in the status quo. We also find that Deetz (2001) provides a key dimension by which we can contrast research as he asks whose concepts are used in research. "Elite, a priori" approaches to communication privilege the questions and concepts of the researcher, and tend to define or operationalize research terms prior to the study. "Local, emergent" research, on the other hand, privileges local questions and concepts, defining the issues of interest and the meaning of important terms during the study itself. In the next section, we describe the three research perspectives in terms of their orientation toward these issues as we discuss their views of theory.

Scientific discourses: defining and judging theory

Scientific perspectives in health communication generally orient toward the universal, as they are driven by the goals of prediction, control, and generalization. Theories are judged on the basis of their ability to explain phenomena and to predict relational patterns among message and process variables identified by the health communication scholar (Chafee & Berger, 1987; Dutta-Bergman, 2005). The goal is to identify broader patterns in health communication that apply across contexts, and hold true above and beyond the contextual limits. Given these goals, theories such as the Health Belief Model, Theory of Reasoned Action and the Extended Parallel Process model seek to explain human behavior in universal terms, based on certain primary characteristics of communication phenomena. Post-positivist research may orient either toward a material or a social constructionist view of reality, but the research itself is generally judged with theories of validity that suggest a correspondence model of truth. Post-positivist research is generally associated with the status quo; quantitative measurements often study *what is* rather than *what could be*, so that existing social arrangements are taken as a given (Bochner, 1985). However, because health communication research tends to be interventionist, this research does orient toward some level of change, albeit in the realm of individual behaviors and lifestyles, leaving dominant social arrangements intact. For example, scholarship focused on improving the quality of physician–patient interaction rarely proposes altering the structural barriers to care or even the biomedical model itself.

Post-positivist research describes theory testing and theory building as an "objective" process in which values and biases are counteracted by the scientific method. Yet, as we have articulated in this chapter, this presumed objectivity hides a number of values in the dominant approach to health communication. These include assumptions of the universality of the biomedical model and endorsement of theories of health that emphasize lifestyle factors as the root of health problems (Lupton, 1994). Campaigns that predict individual level behaviors such as healthy eating and exercising, and develop messages to alter the underlying beliefs and barriers associated with these behaviors, tend to privilege the a priori concepts and issues behind those theories and give less attention to the sociocultural and environmental factors that are integral to the health experiences of individuals, groups, and communities. Much of this research on campaigns assumes the superiority of the health solution being proposed, without interrogating the contexts within which health and illness are situated. Promoting five servings of fruits and vegetables to reduce cancer risk appears to be a value neutral approach, but we note that the lifestyle approach does not address material barriers to compliance and it obscures the environmental, sociocultural, and economic risks of cancer. The emphasis on the individual not only reflects a eurocentric cultural bias, but also serves the political role of determining the key topics in policy agenda, and shifts attention away from the need for structural changes in social systems that promote unhealthy conditions (Dutta, 2007).

Interpretive and critical scholars have developed alternative theoretical approaches that adopt an explicit value-orientation. The interpretive framework is often thought of as an alternative to this dominant scholarship in health communication, exploring issues of local meaning rather than universal generalizations.

Interpretive discourses: defining and judging theory

In an interpretive framework, health communication theorists provide descriptions of health communication processes, orienting toward a concern with the specific. In other words, the role of theory under this framework is to provide a detailed account of the processes and phenomena that are enacted in health settings. Theories within the interpretive paradigm are committed to the local contexts within which health meanings are constituted, health-care relationships are negotiated, and health practices are enacted. Rather than test concepts defined by researchers, in interpretive research, the concepts and issues studied emerge through the research process itself (Anderson, 1987; Charmaz, 2002).

Following its hermeneutic and phenomenological roots, this perspective focuses on how reality is socially constructed. Instead of questions of validity, which assume that findings can be compared against objective reality (or at least triangulated), interpretive theories are evaluated in terms of the

richness of the accounts they provide of health communication processes, and the extent to which they equip us with an understanding of the health experiences of the participants. Insight, utility, and the ethics of the research process itself are important criteria for judging interpretive research (Bochner, 1985; Patton, 2002).

The universal–specific relationship is dialectical, however, and this is a frequent point of misunderstanding across perspectives. Geertz (1973) describes how interpretive theories of culture differ from the aims of prediction, control, and generalization, noting that interpretive theories should "stay rather closer to the ground" (p. 55). Yet interpretive researchers do not completely ignore the "universal" that exists in tension with the "specific." Whereas Geertz states that "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" (p. 56), he also notes that theory building is a dialectic between local and more generalized knowledge. Theory building occurs "between 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).

Focusing on description, interpretive research allows research concepts and concerns to emerge from the study itself (local emergent). This focus on description often leads interpretive scholars to orient toward understanding social consensus rather than critiquing that consensus or seeking transformation (Deetz, 2001). This orientation can be contrasted with critical perspectives.

Critical discourses: defining and judging theory

Whereas interpretive approaches to the study of health communication emphasize the descriptive act, critical discourses add explicit focus on the critique of social relations and social change (Waitzkin, 1991). Critical studies evaluate theory in terms of the degree to which it opens closed systems of meaning for assessment and provides for the possibility of changing the status quo related to health and health outcomes. One of the goals of critical theory is to understand the communicative processes and meaning constructions in the realm of power, thus exploring the ways in which communication is constituted within structural realms, and the processes through which the discursive constructions of health reflect and reinforce dominant power structures (Lupton, 1994; Mokros & Deetz, 1996). Simultaneously, critical studies also provide entry points for looking at the ways in which human agency is enacted as social actors resist power relationships through various communicative acts.

Critical scholars may take multiple approaches toward the materiality/social construction dialectic. Because of the commitment to social change, critical

research generally explores the connections between discourse (as both talk in interaction and in the Foucauldian (1980a) sense of systems of thought, ideas, assumptions, and practices that constitute power/knowledge configurations) and the material conditions surrounding the production of discourse. While some in the Marxist tradition emphasize the relationship between communication and pre-existing material realities (Dutta & Basu, 2007), critical–interpretive and critical postmodern perspectives emphasize the relationship between constructed views of reality and power relations, positioning materiality in a mediating role (Lupton, 1995; Waitzkin, 1991). Theoretical commitments to issues of power and inequality mean that critical scholars may seek understanding at the local emergent level in data gathering, and then introduce what can be considered elite, a priori concepts such as ideology and hegemony in terms of analysis.

We can evaluate critical theories in terms of their contributions to our understanding of relationships between discursive meanings and material realities, and the ways in which these meanings reflect and reinforce dominant interests. Critical theories are concerned with praxis, so we also judge critical theories in terms of their emancipatory potential. This emancipatory potential may be achieved through ideology critique in the Frankfurt school tradition, reclaiming conflict from apparent consensus with the goal of overcoming false consciousness to allow actors to represent their own social interests (Deetz, 2001). Deetz (2005) also describes "communicative action" (Habermas, 1984) as an alternative approach to ideology critique. Here, critical scholars focus less on the substance of value conflicts and more on the possibility for symmetrical communication processes based on procedural ideals. This work can be judged in terms of its ability to facilitate more open and inclusive dialogue.

Cultural studies: defining and judging theory

Cultural studies scholarship examines the intersections of critical and interpretive frameworks by locating discourse in the realm of culture and by connecting the exploration of discourse to the structures that surround the discursive spaces. The locally situated narratives, identities, and relationships of cultural participants are constituted within the broader framework of the culture, and are negotiated in the realm of social structures that define the possibilities of discourse (Dutta, in press; Dutta & Basu, 2007). The cultural studies approach explores the ways in which the stories of cultures perpetuate hegemonic configurations, and thereby serve the status quo. In this sense, the cultural studies approach judges research in terms of its ability to connect issues of meaning, culture, and power. Culture, as conceptualized in cultural studies, is dynamic and constitutive rather than being conceptualized in terms of a stable set of characteristics as articulated in the cultural differences approach of post-positivism. By examining the interplay of hegemony and ideology in the constitution of health discourse, critical–cultural studies draw our attention to the marginalizing practices of the dominant frameworks of health communication, and the possibilities of social change through the rupture of these dominant frameworks (Basu & Dutta, 2007).

Methodological issues in health communication theory

The paradigms within which health communication theories are proposed are also tied to the methodological approaches that inform health communication scholarship. In other words, methodological choices are deeply embedded within the paradigms that provide the overarching frameworks for health communication scholarship.

Because post-positivism emphasizes prediction and generalizability, the relevant methodologies tend to be quantitative because they facilitate testing and replication. For instance, physician–patient researchers survey patients to measure relationships between communication (such as satisfaction) and health outcomes, or observe physician–patient interactions and content analyze them based on their communicative features (Street, 2003). Similarly, researchers may study health communication campaigns by measuring self-reports of attitudes, beliefs, and behavioral intentions before and after the campaign (Murray-Johnson & Witte, 2003). When post-positivist researchers use qualitative research, they often treat it as preliminary to quantitative testing (Brashers et al., 2000).

In contrast, interpretive scholarship typically uses qualitative methodologies in order to provide thick descriptions of texts, phenomena, and processes in health settings. Rhetorical scholars provide unique interpretations of texts, helping us to understand how they invite certain meanings in audiences (Perez & Dionisopoulos, 1995; Solomon, 1985; Zoller & Kline, in press). Methods such as focus groups offer descriptions of health phenomena through the group's participation in the constitution of discourse, whereas in-depth interviews are built upon one-on-one face-to-face interviews with participants that dig deeper into the "meanings of things" (Sharf et al., 1996). Ethnographic projects are typically longitudinal in nature and often involve combinations of participant observations and in-depth interviews (Ellingson, 2003). Scholars using ethnographies immerse themselves in the field in order to provide thick descriptions of the health communication phenomena they are studying.

Critical theory is heavily influenced by interpretive perspectives in the communication field. Therefore, this research uses the same array of methodological tools. Analysis typically differs because of the explicit commitment to recovering hidden conflict and challenging dominant power relationships. For instance, critical theorists examining health discourse may use discourse analysis or thematic analysis to understand the ways in which such discourses reflect the dominant positions of power, and are imbedded within

ideological and hegemonic configurations (Lupton, 1995; Zoller, 2005b). From this standpoint, the goal of the critical theorist is to bring out the taken-for-granted assumptions in discourse that reify dominant perspectives and guide practice. By doing so, critical research encourages attention to the conditions for more open and equitable participation in health discourse and practice, and for change in problematic social structures and relationships of power. Similarly, cultural studies emphasize the socially constituted nature of health and locate such social constructions in the realm of power; therefore, such studies typically use in-depth interviews, ethnographies, and discourse analyses to explore the interactions among culture, structure, and agency, with a particular emphasis on hearing the voices of the marginalized (Dutta-Bergman, 2004a, 2004b).

Although critical theorists in health communication generally adopt qualitative methods that allow research participants to help define problems and issues, this does not rule out quantitative methodology. Critical scholars who investigate the health outcomes associated with the macro-level disparities in infrastructures may rely on or produce quantitative methods such as survey-based observations to locate health outcomes in the realm of material disparities (Waitzkin, 1983).

Contributions

The preceding discussion notes the common threads and tensions among interpretive, critical, and cultural perspectives in terms of theory and methodology. Taken together, this research can act in complementary ways to build systematic knowledge. The goals of prediction, description, and critique may operate within a particular study or across research projects to elucidate health communication. Here we provide an initial discussion of the theoretical and practical contributions of interpretive, critical, and cultural research (see also Zoller & Kline, 2008).

Interpretive research informs us about the social construction of health meanings in everyday contexts (DeSantis, 2002; Ellingson & Buzzanell, 1999; Japp & Japp, 2005). Common theoretical concerns include how various groups define the basic concepts of health and illness, including attention to the body, mind, and spirit as well as material dimensions. Interpretive media studies investigate the mediated construction of health and illness (Kline, 2003), such as Barbara Sharf and Vicky Freimuth's (1993) rhetorical analysis of how the televised program *Thirtysomething* depicted the illness experiences of a woman with cancer. From a critical perspective, Zoller (2003b) investigated the political implications of how an auto manufacturer defined health in worksite promotion campaigns, finding that they emphasized individual efforts over attention to the role of occupational health practices, and that employees adopted much of this discourse. Dutta-Bergman (2004a) used a cultural approach to understand how the Santali community in India conceptualizes

health, noting the tensions between adopting the views of dominant groups versus maintaining their own traditions.

Researchers from alternative perspectives have investigated the ways in which issues of identity are central to our understanding of health communication (Elwood, Dayton, & Richard, 1996; Kirkwood & Brown, 1995; Zoller, 2003a). Scholars have investigated the influence of illness on one's sense of self and the influence of group identity on health communication. For example, Harter et al. (2005) critically assessed the degree to which dominant assumptions about age-related infertility discourse about women reflect gendered stereotypes. These perspectives also often focus on the recursive role of culture in constituting and shaping individual understanding of health and illness (Airhihenbuwa, 1995; Dutta-Bergman, 2004a). Culture-centered approaches situate individual identities of health within a continuously shifting terrain of culture that offers the script for understanding and interpreting illness and disease, and for choosing courses of action in response to disease and illness. For instance, Dutta-Bergman's (2004a) narrative co-construction with the Santalis of rural Bengal suggests that the individual choices of healing and curing are based on a polymorphic worldview that celebrates multiple approaches to knowing and places them in complementary spaces that create openings for synergistic co-existence of seemingly contradictory or opposing approaches.

Interpretive, critical, and cultural perspectives also have introduced previously marginalized voices into health communication theorizing, including women, ethnic minorities, and low-income groups (Johnson, Bottorff, & Browne, 2004; Nadesan & Sotirin, 1998; Yep et al., 2003). For instance, in their work on the culture-centered approach to health communication, Airhihenbuwa (1995) and Dutta (in press) emphasize the relevance of exploring the intersections of culture, structure, and power among marginalized cultural groups. Dutta-Bergman (2004a) suggests that meanings of health are constituted at the intersections of culture and structure; the privileging and silencing of different culturally situated approaches, and the rational universalization of certain approaches over others are predicated upon the knowledge structures and power differentials that underlie these cultural spaces. Drawing upon the transformative politics of postcolonial and subaltern studies theories, the culture-centered approach then seeks to interrupt the dominant logics of health communication by noting the violent erasures of alternative epistemologies achieved through the rational scientific enterprise of modernity, and co-constructs alternative epistemologies of health through relationships of solidarity with marginalized groups that have otherwise been silenced in the dominant spaces.

It is this commitment to transformative politics that is evident in the works of health communication scholars studying the ways in which health-care policies are discursively constructed, implemented, and circulated (Conrad & McIntush, 2003; Melkote et al., 2000). Scholars are coming to explore the role

of health activism in challenging the unhealthy structures of health and bringing about changes in global health-care policies that create and sustain health inequities across the globe (Christiansen & Hanson, 1996; Fabj & Sobnosky, 1995; Sobnosky & Hauser, 1999; Zoller, 2005a). Researchers are building our understanding of community-based approaches to health promotion focused on local empowerment (Ford & Yep, 2003; McLean, 1997; Minkler, 1997).

This discussion of contributions is preliminary. The chapters in this book will describe a number of other theoretical and practical contributions of these "alternate" perspectives that address issues of meaning, culture, and power. In the next section, we explain how the book is organized and provide an overview of the major sections and their chapters.

Organization of the book

The book is divided into four parts based on topical similarities. Part I, "Popular discourse and constructions of health and healing," focuses on the emerging interest in discourse, including linkages among textuality, talk-in-interaction, and larger knowledge formations in constructing everyday beliefs about health and illness. After an introduction that situates the chapters within discursive approaches to health communication, Chapter 2 by Cecilia Bosticco and Teresa L. Thompson describes the richness that narrative perspectives contribute to our understanding of health and healing in their chapter "Let me tell you a story: narratives and narration in health communication research." In Chapter 3, "Supporting breastfeeding(?): nursing mothers' resistance to and accommodation of medical and social discourses," Emily Cripe uses ethnography to understand women's discourse about breastfeeding in a support group, and links their communication to larger medical and gendered discourses. Patricia Geist-Martin, Barbara Sharf, and Natalie Jeha's chapter, "Communicating healing holistically," describes the role of communication in holistic healing practices, providing a contrast to the role of communication in biomedical interactions. In Chapter 5, "'You feel so responsible': Australian mothers' concepts and experiences related to promoting the health and development of their young children," Deborah Lupton interviews women to understand how mothers talk about promoting the health of their children, connecting their views to larger social constructions of responsibility, health, and motherhood. Finally in Chapter 6, "Destigmatizing leprosy: implications for communication theory and practice," Srinivas R. Melkote, Pradeep Krishnatray, and Sangeeta Krishnatray discuss the role of stigma in health care, situating the care of leprosy within neoliberal models of health and development, and suggesting the relevance of participatory processes in creating community-based health communication efforts. These chapters draw our attention to the selective nature of discourse; just as certain dominant understandings are selected and foregrounded, other understandings are

omitted and backgrounded in the discursive space. The emphasis is on understanding the discursive formations within which health comes to be constructed and codified; it is, after all, within these discourses that (im)possibilities of health practices are imagined.

Part II draws our attention to alternative approaches to health campaign scholarship that sensitize us to the cultural rootedness of health promotion efforts. The section introduction describes the development of research in culturally based participatory health promotion. In their chapter titled "Teach-with-stories method for prenatal education: using photonovels and a participatory approach with Latinos", Susan Auger, Mary DeCoster and Melinda Colindres describe how photonovels can be used to make prenatal education more culturally appropriate through the sharing of stories. Story-telling encourages active participation among women in the education process. The theme of culturally based participatory communication is also articulated in Chapter 8, "Ethical paradoxes in community-based participatory research," by Virginia McDermott, John Oetzel and Kalvin White, which discusses the ethical paradoxes in community-based participatory research. The chapter brings out the various tensions that are inherent in community-based participatory research processes as researchers engage with community members in the production of knowledge. In Chapter 9, *Voces de Las Colonias*: dialectical tensions about control and cultural identification in Latinas' communication about cancer, Melinda Villagran, Dorothy Collins, and Sara Garcia participate in co-constructive meaning making with Latina community members to explore these residents' interpretations and explanations of health and illness around cancer. Through this co-constructive journey, the authors elucidate the tensions around control and cultural identification that circulate in this cultural community. Chapter 10, *El Poder y La Fuerza de la Pasión: toward a model of HIV/AIDS education and service delivery from the bottom-up*, presents the concepts of critical health communication praxis, "third-order" research, and collaborative community dialogue to describe the communicative strategies utilized by the organization Proyecto ContraSIDA Por Vida (PCPV) in Latino communities in San Francisco, California. Finally, Chapter 11, "Interrogating the Radio Communication Project in Nepal: the participatory framing of colonization," concludes Part II by utilizing the basic tenets of the culture-centered approach (Dutta-Bergman, 2004a) to interrogate the participatory claims of the Radio Communication project in Nepal; the chapter details the ways in which participatory avenues might be co-opted to serve the goals of planners in top-down hegemonic agendas. Each of the chapters in this section elucidates the tenets and tensions invoked by the culture-centered approach to health communication, drawing out the interactions among culture, structure, and agency in the realm of health meanings and health communication processes. The chapters engage with the contextually embedded nature of culture that is simultaneously regenerative and transformative; therefore, each of these chapters suggest openings for transformative politics

in the realm of how we think about health communication and the ways in which health communication practices might be mobilized in solidarity with cultural members.

Part III focuses on communication in medical settings. The section introduction describes the growth of interpretive, critical, and cultural research into communication that constitutes and supports biomedical approaches to health care. The following chapters represent emerging interest in medical settings outside the standard physician–patient interaction as well as issues of power in medical communication. In Chapter 12, "Contested streams of action: power and deference in emergency medicine," Alexandra Murphy, Eric Eisenberg, Robert Wears, and Shawna J. Perry investigate the role of power and authority in sense-making processes in an emergency department, describing the influence of systems of authority on patient care through extended examples from their extensive observations. In Chapter 13, "Changing realities and entrenched norms in dialysis: a case study of power, knowledge, and communication in health-care delivery," Laura Ellingson provides in-depth understanding of how macro-level issues, including acute care models of health and professional hierarchies, influence everyday interaction in a dialysis care clinic where paraprofessionals must deal with chronic illness. Chapter 14, "Changing lanes and changing lives: the *shifting* scenes and *continuity* of care of a mobile health clinic," by Lynn Harter, Karen Deardorff, Pamela Kenniston, Heather Carmack, and Elizabeth Rattine-Flaherty, is an ethnography of a mobile health clinic. The authors focus on how health-care workers improvise to manage the physical and material barriers to care they face in this mobile unit. Finally, in Chapter 15, "The paradox of pharmaceutical empowerment: Healthology and online health public relations", Ashli Quesinberry Stokes takes us out of the clinic and onto the web, where she examines the contradictions of pharmaceutical rhetoric on the site "Healthology." She describes the paradox of "empowerment" discourse and its influence on audience identity. This section illustrates how the emergence of qualitative research such as ethnography, observation, and textual analysis expands the existing literature by focusing on issues of meaning, culture, and power in medical communication. As such, these chapters are excellent models of research that is both theoretically and practically grounded, with clear implications for the revision of dominant medical scripts.

Part IV represents what is in some ways the most newly emergent trend in health communication by focusing on health policy. As we describe in the section introduction, we see this area of the book drawing together the previous chapters that address popular discourses of health, community and culturally based health promotion, and medical communication, because it investigates how formal and informal political processes structure the experience of health at these other levels. This section also represents newly emerging attention in the field to issues of globalization. The chapters address the influence of transnational trade policies on pharmaceutical pricing and access, public health

protections, food security, and genetic research. It begins with Chapter 16, "Dealing drugs on the border: power and policy in pharmaceutical reimportation debates," by Charles Conrad and Denise Jodlowski. These authors engage in a rhetorical analysis of the interrelation of U.S. and Canadian pharmaceutical policy making, describing the processes through which elites may outflank public groups through overt and hidden forms of influence. In Chapter 17, "Technologies of neoliberal governmentality: the discursive influence of global economic policies on public health," Heather M. Zoller broadens the definition of health policy to examine critically the governmental discourse of neoliberal trade mechanisms from the perspective of public health. The chapter encourages attention to multisectoral policy activism and advocacy as a form of health promotion. Chapter 18, "The paradox of 'Fair Trade': the influence of neoliberal trade agreements on food security and health," by Rebecca DeSouza, Ambar Basu, Induk Kim, Iccha Basnyat, and Mohan Dutta focuses on the impact of neoliberal trade policies on one of the most important elements of public health—access to adequate and safe food and water. Finally, in Chapter 19, "Globalization, social justice movements, and the human genome diversity debates: a case study in health activism," Rulon Wood, Damon Hall, and Marouf Hasian describe the politicization of the Human Genome Diversity Project (HGDP), an attempt to accrue diverse genetic samples ostensibly to create a more complete genetic map. The chapter traces the development of activism among subaltern groups as alliances form to contest the perceived colonialist assumptions of the project, and describes how the leaders of the project responded to this activism. We believe that these chapters provide a foundation for continued research into communication and health policy making that addresses a broad array of policies that influence the health contexts we study.

In the Afterword, the editors discuss the overarching contributions to health communication research made by the chapter authors. We describe how the interpretive, critical, and cultural perspectives in this book contribute to health communication theory and practice. We also discuss how we can expand on these through our future research agendas. Finally, given the growth of multiple theoretical and methodological perspectives in health communication, we talk about how the field can maintain productive dialogue across different philosophical and methodological commitments.

Conclusion

In conclusion, this chapter laid out the foundation for examining the different ways in which theory is conceptualized in health communication scholarship. The evaluative criteria that are applied in order to examine various health communication theories vary with the specific paradigms within which these theories are located. Also, our discussions pointed out the different methodological commitments that align themselves with the different

approaches to theory building, suggesting that methodological questions emerge from the broader theoretical net that is cast on a specific health communication problem. Interpretive, critical, and cultural studies offer new ground for health communication scholars in conceptualizing communicative phenomena around health, studying these phenomena, and implementing them in practice.

As we pointed out here, whereas much of the existing scholarship in health communication falls under the rubric of the post-positivistic approach, recent trends demonstrate an increase in the number of articles that study health communication processes from interpretive, critical, and cultural approaches (Beck et al., 2004). This trend warrants discussion about avenues for engaging in and presenting such scholarship, as well as useful directions for building theory and practice. The chapters in this book provide valuable exemplars of how the study of health communication phenomena may be approached from interpretive, critical, and cultural perspectives.

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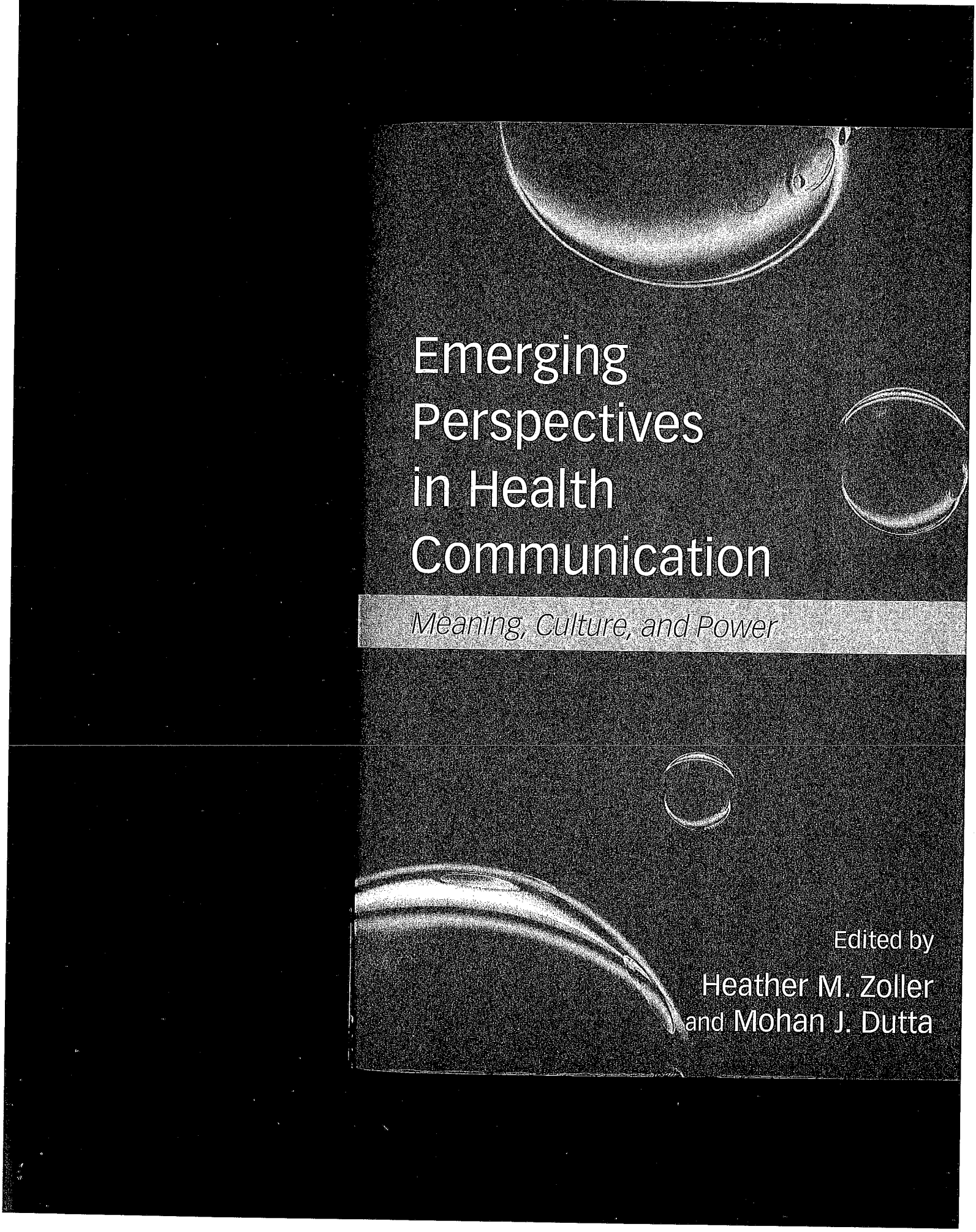
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