

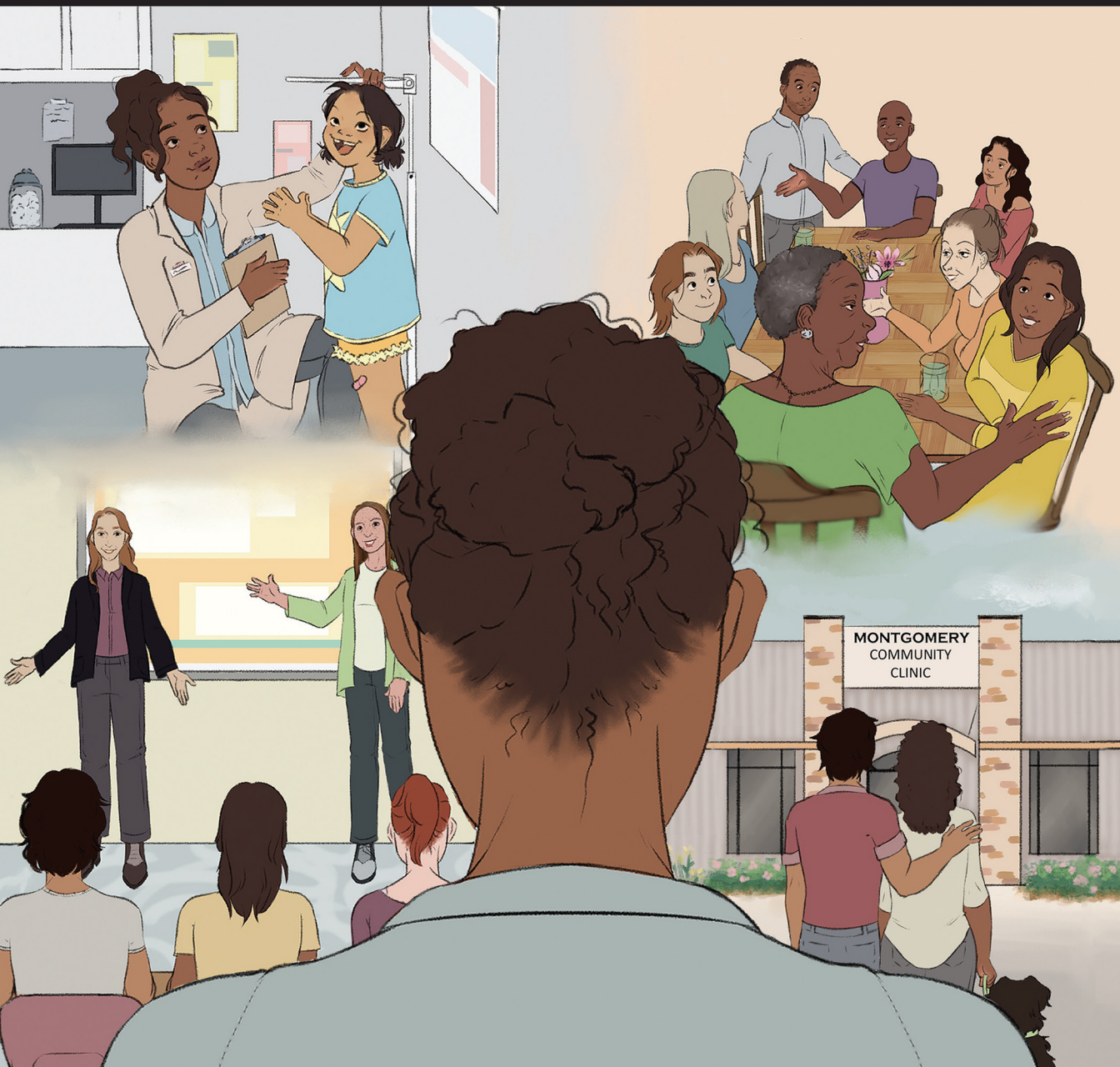
Nancy Grant Harrington and
Rachael A. Record



Health Communication

Research and Practice for a Diverse
and Changing World

SECOND EDITION



“My excitement for this book cannot be overstated. As our society more fully grapples with the complexities of health communication laid bare during the COVID-19 pandemic, and students from all disciplines want to become more knowledgeable about issues of health communication, this text will provide a solid, informed, and sensitive look at our field. This book, which nicely incorporates both the breadth and depth of our field, will serve as a useful resource for faculty teaching upper level health communication classes to students from all backgrounds. It is one that not only mentions but also deeply and actively grapples with issues of diversity, discrimination, medical ethics, and access issues across its fifteen chapters. Nowhere is this more clear than in the inclusion of the Montgomery family story, a companion narrative to accompany the textbook chapters that will be a phenomenal pedagogical feature for engaging with undergraduates. I look forward to adopting this book the next time I teach health communication.”

— **Katharine J. Head**, *Indiana University-Purdue University
Indianapolis, USA*

“I have been using the first edition of this book since it was published, and I am eager to adopt the second edition, *Health Communication: Research and Practice for a Diverse and Changing World*. Health communication is a diverse, dynamic, and rapidly developing field of study. To capture the many facets of our field and translate them within a context of higher education is no small feat. Having thoroughly reviewed this second edition, I believe that Drs. Nancy Harrington and Rachael Record have developed a textbook that will accomplish that feat. One of the ways the authors address the conundrum of competing against material that becomes rapidly outdated is to center chapters within more overarching theoretical approaches, which are then supported by individual research studies. For example, I may be biased as a scholar of technology and media adoption, but nothing seems to lose its shelf life quite so quickly as ‘new’ communication technology research, *unless* the research is well supported theoretically. Thus, although media consumption, technology use, broadband access, etc. are deeply interwoven with health and communication, chapters *about* these topics (e.g., ‘new technologies in health communication,’ ‘internet and eHealth’) quickly become outdated. The authors have addressed this issue in multiple ways, for example, focusing on health information seeking (online and offline), which will ensure usability for many years to come. Finally, *Health Communication: Research and Practice for a Diverse and Changing World* follows the lead of the subtitle change. In the second edition authors both add and reorder information to prime readers to think about how others may experience health and engaged a strategy that I hope will help those of us who adopt this textbook to inspire discussion and action that will achieve each decade of the U.S. government’s Healthy People goals – ‘improve the health and well-being of people.’ All people.”

— **Kate Magsamen-Conrad**, *The University of Iowa, USA*

“*Health Communication: Research and Practice for a Diverse and Changing World*, piloted in my 300-level Introduction to Health Communication course, was very well received by a large and diverse group of students ranging from communication to kinesiology majors. The students particularly appreciated the relevant and timely content, health justice-based case studies, and the narrative flow of the text. I am confident and excited about utilizing this textbook as a resource for my future classes.”

— **Rati Kumar**, *San Diego State University, USA*



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Health Communication

This thoroughly revised second edition covers the major areas of research, theory, and practical application in health communication.

This textbook takes an in-depth approach to health communication by analyzing and critically evaluating research conducted across multiple paradigmatic perspectives and focusing on translational application of research findings. Using the story of the Montgomery family, a biracial, multigenerational family, and their health experiences as a case study, chapters explore topics including patient–provider communication, health communication in the media, ethical issues, and public health crises. New chapters cover the potential for communication to address discrimination in healthcare settings, health information seeking, social support and caregiving, and the relationship between health and environmental communication. Chapters offer pedagogical features that will prove useful to students and instructors of health communication, such as summary boxes, theory tables, suggestions for in-class activities, discussion questions, and lists of additional resources.

Developed for use in advanced undergraduate and master’s level health communication and public health courses, this text represents the breadth and depth of health communication theory and research as it exists today.

Online resources for instructors including additional theory tables, PowerPoint slides, test questions and assignments, sample syllabi, and lists of additional resources are available at <https://www.routledge.com/9781032100470>.

Nancy Grant Harrington is a Professor of Communication in the College of Communication and Information at the University of Kentucky, USA.

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Health Communication

Research and Practice for a Diverse and
Changing World

**Nancy Grant Harrington and
Rachael A. Record**

2nd Edition

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To Dan O'Hair, our dear friend, colleague, and mentor, who thoughtfully wrote the foreword to the first edition of this book. May your selflessness and dedication to mentoring students, faculty, and staff stand as an example to all who follow you.

You are gone too soon.





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Preface



Welcome to the second edition of *Health Communication: Theory, Method, and Application*, which is now titled *Health Communication: Research and Practice for a Diverse and Changing World*. The first edition of this text, published in 2015, was written to provide a theory, method, and metatheory-driven review of health communication scholarship for upper-division and master's level students in communication and related disciplines. It was designed to fill a gap between textbooks written for lower-division courses and *The Routledge Handbook of Health Communication*, which is more suited for graduate studies. This second edition represents our effort not only to update the material, certainly necessary after nearly a decade, but also to better meet the needs of the post-pandemic undergraduate audience and more directly confront the challenges of health communication in our complex and complicated society.

For this second edition, we took to heart the feedback we received from scholars recruited by Routledge to review the first edition and provide direction for the second. There were four themes that emerged from the reviews. First, reviewers noted some inconsistencies in chapter voice and style due to the nature of the edited textbook. After much deliberation, we decided that the second edition would be an authored text to allow for greater control and consistency across chapters. Second, reviewers noted that the technology chapters were out of date and limited. Our solution was to no longer include specific chapters on technology but to mention in every chapter how technology comes into play in various contexts and how it influences health communication processes and outcomes. We also took a similar approach with social media, including research on social media across chapters when applicable instead of having a specific section on the topic in the chapter on health communication in the media. Third, reviewers called for a more direct discussion of practical and translational applications of textbook content. This recommendation, coupled with feedback we had received from instructors over the years indicating that the emphasis on metatheory was perhaps beyond what was needed for an undergraduate text, led us to address paradigmatic perspectives only in Chapter 1 as part of providing a foundation for health communication scholarship and put our emphasis in remaining chapters on study findings and their implications. Finally, reviewers called for greater attention to challenges surrounding discrimination in healthcare. This became a central part of our vision for the second edition. We have added a new chapter on discrimination and what it means to be antiracist in health communication, and we have infused findings related to discrimination in its multiple forms in every chapter. In addition, as a way of rejecting white nationalism and being allies to our students and colleagues of color, we have chosen to capitalize ethnicities of color but use lower case for the white racial identity.

We think it's important for us to acknowledge that we are two cis white women with a middle-class upbringing, as well as being first-generation college students with a privileged education. We recognize that our ability to fully understand and appreciate experiences of discrimination and their significance for health communication research and practice is limited by those lenses. As allies, though, we believe that discrimination in healthcare is a priority that cannot be ignored, and so we did our best to represent those concerns by highlighting the voices of individuals from these communities and the community-driven work being done therein. We also recognize that talking about "isms" and bias can sometimes make people uncomfortable. Such talk in today's society, however, is essential. We hope everyone realizes this, as well as realizing that confronting one's biases—implicit or explicit—helps everyone in the long run.

One other change we made to the text is to develop and share the story of the Montgomery family, a biracial, multigenerational family whose daughter, Cheryl, wants to be a physician and discovers health communication along her journey. Each chapter begins with an installment of the story, which serves to highlight topics covered in the chapter. The

main characters, most of whom are included in the family tree pictured at the start of this preface, were illustrated by a graduate of the University of Kentucky College of Fine Arts. Because health and illness are embodied and experienced through narrative, we hope the Montgomery family's story will provide an opportunity for readers to delve deeper into the concepts covered in the chapters.

Organization and Features of the Book

This textbook has 15 chapters organized into six sections. The first section, *Understanding Health Communication Foundations*, includes an introductory chapter on health, healthcare, and the discipline of health communication and a chapter on discrimination and health communication. The second section, *Being a Patient*, contains chapters on patient–provider communication; patient experiences of uncertainty, decision making, coping, and health literacy; and health information seeking. The third section, *Caring for Patients*, includes chapters on healthcare provider roles and perspectives, social support and informal caregiving, and end-of-life communication. The fourth section, *Health Communication Challenges*, addresses mental health and mental illness, intercultural health communication, and ethical issues in health communication. The fifth section, *Societal-Level Health Communication Concerns*, covers health communication in the media, environmental health communication, and public health crises. The last section, *Looking Forward*, offers a chapter focused on practical information for students wishing to continue their studies in health communication, find a career in health communication, or become allies in efforts to end discrimination and promote patient empowerment.

This book has several pedagogical features that facilitate its use as a textbook. Each chapter has summary boxes to highlight main points of the chapter. **Key terms** are in boldface throughout the text. The theories guiding the research studies presented in each chapter are summarized in theory tables that list the name of the theory (or model or framework), provide a summary of the theory's principles, and offer a reference for further reading. Each chapter also has suggestions for in-class activities and discussion questions.

Changes to the Second Edition

We've touched on several of the changes to the second edition already, but we present them here in bulleted form for ease of reference.

- The book is authored instead of edited.
- The book's title has been updated to reflect changes in content and emphasis.
- The literature has been updated.
- Although many of the concepts covered in the book could apply to multiple chapters, chapters have been organized to avoid overlap.
- Chapters no longer emphasize the metatheoretical or paradigmatic perspectives of the research reviewed but instead emphasize study findings and their implications.
- There is a stand-alone chapter devoted to discrimination and health communication, and issues of discrimination are addressed in each chapter.
- There is not a stand-alone chapter on technology; instead, technology is addressed in each chapter as applicable. Likewise, there is not a specific section on social media in the chapter on health communication in the media; instead, research on social media is included across chapters when applicable.
- Each chapter includes a theory table for ease of reference.

- There are expanded online resources, including a comprehensive theory table to provide opportunities for instructors to highlight additional theories they might like to include during lectures or possible student assignments.
- Each chapter begins with an installment of the Montgomery family narrative as a way to bring some of the topics addressed in each chapter to life.

Student Evaluations

We were fortunate to be able to pilot test most of the chapters of the book with undergraduate students. We collected evaluations on the chapters, asking students what they liked most and least about each one, what they found confusing, what parts they thought should be longer or shorter, and whether there was anything they would change. We also asked students to rate the chapters along several dimensions (e.g., interest, relevance, writing style). Overall, 89% of students found the chapters to be somewhat or extremely interesting, 90% found them to be somewhat or extremely easy to follow, 94% reported learning some or a lot, and 92% felt the chapters would help them some or a great deal in real life as a patient, caregiver, or employee in the healthcare industry.

Online Resources

Online resources are available for students and instructors. Students will be able to download files from the textbook's page on the Routledge website. Materials include a list of additional resources for each chapter, such as movies and documentaries, podcasts and TED talks, and other relevant resources (e.g., websites, YouTube videos). There is also a table consolidating all the theories that were included in the chapter theory tables and adding other relevant theories that did not get addressed in the chapters. The student section also includes the full Montgomery family narrative with color images, as well as the notes for each installment. Instructors will be able to access chapter quizzes, reflection assignments, PowerPoint® slide decks, and sample syllabi through Routledge's Instructor Hub, whose link is also available on the book's page on the Routledge website.

Audiences for the Book

As with the first edition, this textbook is targeted toward upper-division undergraduate and master's level students in health communication and other social and behavioral sciences, as well as students in the health professions. We anticipate that programs in communication will be most likely to adopt the book; however, other social and behavioral science disciplines such as health education and public health may also find the book to be of interest. Avid health communication scholars of any background also may be interested in the book.

As you adopt *Health Communication: Research and Practice for a Diverse and Changing World* for your courses, we hope you find it engaging and easy to use. We hope your students like it, as well. We've done our best to be undergraduate friendly. If you have any feedback you'd like to share, we'd love to hear from you. Best wishes for a successful class!

Special Thanks

We have several people to thank. First, thank you to all the chapter authors from the first edition of this book. Your work was outstanding, and we are grateful for your contributions. Special thanks also go to our amazing artist, Ash Garrison, whose talent brought

the Montgomery family characters to life. Thanks, as well, to Rachel Crick, Brittany White, Courtney White, and Dr. Brittany Lash for providing invaluable feedback on the Montgomery family narrative. Thank you to Max Groznick for providing helpful assistance with chapter evaluations during pilot testing. And special thanks to Dr. Rati Kumar for allowing us to pilot our chapters in her health communication course. Finally, we want to thank Alexandra de Brauw, publisher, and Sean Daly, senior editorial assistant. We are grateful to them and to Routledge/Taylor & Francis Books for making this second edition possible.

Nancy Grant Harrington
Rachael A. Record



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Unit I

Understanding Health Communication Foundations



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Meet Dr. Cheryl Montgomery



Cheryl sat nervously in her chair, wishing her palms would stop sweating. Over the past few years, she'd already done a number of successful interviews. But this would be her first time discussing the more personal aspects of her life. Despite the butterflies in her stomach, she was really looking forward to this interview. And following a nod from the host, she saw the light in the studio turn red, indicating they were recording.

"Welcome, folks, to episode 323 of *The People Who Made Me*. I'm Bryce Thomas Patrick, your host. If you're new to the show, each week we listen to the personal journey of someone who is changing the world. But we don't just ask them about what they've done. We want to know about all the people who helped them along the way. And today, we have with us Dr. Cheryl Montgomery, the 40-year-old visionary who's changing the world through community health. Welcome, Dr. Montgomery!"

"Thanks, Bryce. I'm very excited to be here," Cheryl replied.

"Not as excited as we are to have you here," Bryce responded. "Now, Dr. Montgomery, I'm sure you know the drill. We ask our guests to talk us through their stories and tell us

how they found themselves on such unique and impressive career paths. And with you, we've started off really strong. You're a double doctor? An MD *and* a PhD?" Bryce said with eyebrows raised and hands out. "Wow!"

"Well, yes," Cheryl said, blushing a bit. "I started out wanting to be a doctor, but then I discovered health communication. So after I earned my MD, I went back to school to earn my PhD. Given what I wanted to do, it made sense."

"That sounds like a lot of school, but pretty awesome," Bryce laughed. "Now, not to spoil the end of the story, but you're a renowned expert in environmental breast cancer research, and you're the founder and director of the *Helen Montgomery Community Clinic for Breast Cancer Awareness and Prevention*. Where did this journey start for you?"

"Well," Cheryl said, nodding as she decided where to begin. "I knew at a young age that I wanted to be a doctor. I grew up in a small town where a lot of people were dealing with so much disease and illness and so many health complications. I wanted to be part of the solution, to help the people in my community."

"That's a big dream for a kid. Were people generally supportive?" Bryce asked.

"My family was," Cheryl replied. "But some of the adult figures in my life at the time didn't think I had what it took to become a doctor."

"You're joking, right?" Bryce asked.

"I'm not, actually," Cheryl said. "When I was a junior in high school, I told my counselor I wanted to be a doctor. Believe it or not, she said it wouldn't be a good fit for me."

"What? Clearly, she was wrong," Bryce replied.

"Well, yes, but I didn't know that at the time. As a teenager in high school, it felt more likely that I was wrong. But when I told my dad about what she said, he literally said, 'To hell with that!' and 'You can be anything you damn well want to be!'" Cheryl recounted, lowering her voice to sound more like her dad. "He's protective like that. He made sure that I didn't let the counselor make assumptions about me—about who I was or what I was capable of. Because of his encouragement, I ended up enrolling at the top university in our state—with a scholarship."

"Well, that's a great start to a dream path," Bryce observed.

"It sure was," Cheryl smiled. "So like a lot of eighteen year olds, I went off to college as a wide-eyed first year student, ready to take on the world and feeling invincible."

"Ready to take on the world, with a little push from your dad," Bryce noted.

"That's right," Cheryl said, smiling. "My dad, Joe."

"And who else? Who else played a role in your journey? Or should I say, who's your cast of characters?"

"Well, there's my grandmother, Helen," Cheryl answered. "She's probably the most important person in my story, especially as far as my research into breast cancer goes."

"And how would you describe Helen?" Bryce asked.

"Vibrant. Warm. Feisty. She was the whole package," Cheryl answered, feeling her eyes get a little teary as she thought about her favorite person.

"And there's my stepmom, Sally," Cheryl continued. "She adopted me shortly after she and my dad got married. I would describe her as creative and dedicated to her family. She's definitely the heart of the Montgomery family."

"Any brothers or sisters?" Bryce asked.

"One. My sibling, Sam, who's actually my stepmom's child. And my dad adopted him as well."

Bryce nodded. "Younger or older?" he asked

"Younger," Cheryl laughed. "By seven years. And despite not being genetically related, I'd say we had a very typical sibling relationship. Sam drove me crazy, and I'm sure I did the same. But we're really close."

“So, he was pretty young when you left for college?” Bryce asked.

“Eleven,” Cheryl said, nodding. “It was hard to leave them at home and go off to college. But I knew that’s what I needed to do, for me.”

“Of course,” Bryce acknowledged. “So, anyone else we should know about?”

“Well,” Cheryl said, thinking for a moment. “My Uncle Michael and cousin Monica. They’re both in healthcare, too. I call Uncle Michael my Jiminy Cricket, and Monica, well, she’s my rock. She’s the strongest person I know. And my Aunt Savannah. She was Sally’s sister, but she really loved being around our family, so we took her in...despite her rougher edges.” Cheryl cleared her throat a bit. “And then there are my two best friends, Nathian and Liz. We met during our first year of college and bonded for life. Funny enough, Liz was pre-med with me, and Nathian was majoring in health communication, so it all kind of fit. And those are my people.”

“Okay, perfect,” Bryce replied. “So, we have your people, and we know that if you hadn’t ignored that high school counselor, you might not be sitting here right now. So, what else, Dr. Montgomery? Tell us your story.”

“Well,” Cheryl began. “I guess it begins about twenty years ago as I went off to college...”

1 Introduction to Health, Healthcare, and Health Communication

Welcome to health communication! We want to start off this learning adventure with two healthcare jokes.

- A man calls the doctor's office and says frantically, "My wife is pregnant, and her contractions are only two minutes apart!" "Is this her first child?" the doctor asks. "No, you idiot!" the man shouts. "This is her husband!"
- A patient goes to the doctor for a follow-up visit. The doctor says, "You look much worse than you did last week! I said you should smoke a maximum of five cigarettes a day!" The patient replies, "That's exactly what I did! And it wasn't easy—because up until now, I didn't smoke at all!"

We hope these jokes gave you a bit of a chuckle. But they're meant to do more than tickle your funny bone. We shared them to highlight how easy it is to think you're asking simple questions or making clear requests when there's actually still plenty of room for misinterpretation. The cases above are arguably harmless, but there are multiple examples of when miscommunication has led to much more serious outcomes. That's something everyone wants to avoid, and it's where the discipline of health communication comes into play (although it's much broader than that). We're glad you're here to learn how.

We, your authors, have several goals for this book. We want it to offer you a cutting edge, comprehensive presentation of health communication research focusing on a range of essential topics, including patient-provider communication, health information seeking, social support, ethical issues, public health crises, and more. We want it to reveal the challenges and complexities inherent in health and healthcare, including discrimination in its multiple forms, and the kinds of contributions health communication research can make to improve and advance society. And we want it to help you appreciate that although certain principles of health communication apply broadly, the experience of health and illness also is highly personal, affecting each person and their lived lives in unique ways.

When you realize that most of the illness, injury, and premature death in the world can be prevented—and that competent communication is essential to that process—you know that the discipline has a crucial role to play. We're going to use this introductory chapter to lay the groundwork for the chapters to come by reviewing foundational topics in health and health communication. First, we'll provide an overview of perspectives on health. This section will include a critical look at the American healthcare system and a review of the United Nation's sustainable development goals and the U.S. government's *Healthy People* initiative. It will give you an idea of the nature of the healthcare landscape that must be navigated and the health goals that everyone should be working toward to the extent that they are able. Next, we'll provide an orientation to the discipline of health communication,

which will include a brief history of how the field began. This section also will include a discussion of theory, methods, metatheoretical paradigms, and multidisciplinary, interdisciplinary, and translational research. Finally, we'll talk some about the organization of the book and its pedagogical features. Let's begin, shall we?

Perspectives on Health

Although people may think that being healthy just means not getting sick, health is actually much more than that. The World Health Organization (WHO; 1948) defines **health** as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (para. 2). From this perspective, you can think of health holistically and consider what is called **whole person health**. The National Center for Complementary and Integrative Health (NCCIH; 2021, para. 1) explains:

Whole person health involves looking at the whole person—not just separate organs or body systems—and considering multiple factors that promote either health or disease. It means helping and empowering individuals, families, communities, and populations to improve their health in multiple interconnected biological, behavioral, social, and environmental areas. Instead of treating a specific disease, whole person health focuses on restoring health, promoting resilience, and preventing diseases across a lifespan.

Whole person health recognizes that for people to be healthy, healthcare providers, stakeholders, and policymakers must work to promote positive health in all aspects of society, including promoting “healthy behaviors, environments, and policies to maintain health and prevent, treat, and reverse chronic diseases” (NCCIH, 2021, para. 6). The NCCIH lists five exemplar health programs prioritizing a whole health perspective. One of them is the Whole Health Institute (n.d.), which was founded in 2019 to address “physical, mental, emotional, and social well-being by working with health systems, partners, employers, and communities” (para. 1, “About” section). This institute approaches healthcare through a *whole healthcare delivery model*, which they describe as follows (n.p., “Home” section):

- The patient's journey from the time they seek health care to treatment and everything in between
- Reinforced by touchpoints of care that are rooted in evidence-based, whole health approaches
- Delivered by a cross-functional team that assesses individual's needs across a range of physical, mental, behavioral, and social dimensions
- Activated by the individual, who is empowered by self-care tools and resources
- Made financially sustainable through value-based payment models

The perspective of whole person health is a reminder that every human is part of a larger system where everyone's health and health behaviors influence and, for better or worse, are influenced by everyone else's health and health behaviors. These are called **individual-level factors**. For example, if you get a vaccine, it reduces your risk of getting sick, which means you are less likely to get other people sick. At the same time, if you smoke cigarettes, it doesn't just increase your risk of lung cancer—it can increase the risk of lung cancer for anyone who smells the smoke. But it's not just individual-level behaviors that affect health. It's systems-level factors, too.

Systems-level factors are external influences on an individual's health and health behaviors. They are largely outside of an individual's control. They include social, cultural,

mass media, organizational, governmental, and environmental factors, many of which operate without people even realizing their impact. We'll be addressing many of these factors in forthcoming chapters, including social determinants of health in Chapter 2. The two we focus on in this chapter are the healthcare systems within which people seek and receive care and efforts to address systemic factors in order to promote health both nationally and globally. We turn to those topics now.

Healthcare in the United States

Healthcare is provided to individuals within healthcare systems, and these systems vary dramatically based on where you live in the world. In a fascinating account of healthcare systems around the globe, T. R. Reid (2010) compares several nations' approaches to medical treatment and payment for services. There are core variations across the systems based on whether (a) healthcare providers and payers (e.g., insurers, Medicare, Medicaid) are private or run by the government, (b) costs are financed through employers/employees, taxes/premiums, or out-of-pocket expenditures, (c) the systems are non-profit or for-profit, and (d) every citizen is covered or not. Considering these factors in the United States, there is a mix of private and government-run providers and payers; costs are financed every which way, with large amounts coming out-of-pocket from patients; there is a mix of for-profit and non-profit entities; and not every citizen is covered (even with the **Affordable Care Act**, also known as Obamacare). Henry Aaron, a leading healthcare economist at the Brookings Institution, said,

I look at the U.S. health care program and see an administrative monstrosity, a truly bizarre mélange of thousands of payers with payment systems that differ for no socially beneficial reason, as well as staggeringly complex public systems with mind-boggling administered prices and other rules expressing distinctions that can only be regarded as weird.

(Reid, 2010, pp. 43–44)

This quote might be from over a decade ago, but it still is true today.

If Americans were getting exceptional healthcare from this “weird” system, then it might be worth it, but they're not. Did you know that the United States is the only developed nation that doesn't provide some form of universal healthcare to all its citizens? And that medical bankruptcy is unheard of in other developed nations? In the United States, though, even with Obamacare in place, a study by David Himmelstein and colleagues (2019) found that from 2013 to 2016, approximately 530,000 Americans each year declared bankruptcy due to medical bills. Outlandish medical bills are such a problem in the United States that National Public Radio (NPR) and Kaiser Health News (2018–present) co-produce a podcast series called *Bill of the Month* that highlights a personal or family experience with outrageous medical bills “in order to shed light on U.S. health care prices and to help patients learn how to be more active in managing costs” (para. 1).

When comparing large healthcare systems to each other, Reid (2010) explains that healthcare systems can be evaluated along dimensions of cost, quality, and choice. He cites several sources of data to make the claims that “Among the world's developed nations, the United States stands at or near the bottom in most important rankings of access to and quality of medical care” and “The one area where the United States unquestionably leads the world is in spending” (p. 9). In other words, Americans are spending more money for poorer quality and less access. The U.S. healthcare system has more similarities to developing nations' systems than it does to developed nations' systems.

Harvard economist William Hsiao observed that “the creation of a national health care system involves political, economic, and medical decisions, but the primary decision to be made is a moral one” (Reid, 2010, p. 215). Unlike every other developed nation on the planet, the United States has taken a moral stance that not all of its citizens deserve healthcare. Because of that choice, people suffer and die needlessly. Reid wrote his book in the hopes that the United States could learn from other countries that spend less money on healthcare yet have better health outcomes and universal access, but he fears that his argument will fall on deaf ears because of American exceptionalism, or the belief that “our strong, wealthy and enormously productive country...doesn’t need to borrow any ideas from the rest of the world” (pp. 12–13). We think that’s dreadfully shortsighted. We recommend that you consider reading Reid’s (2010) book and see if you want to become a part of working toward the change the U.S. system desperately needs. Part of that change involves national and global efforts to promote health. Let’s start with the global level.

United Nations Sustainable Development Goals

The **United Nations (UN) Sustainable Development Goals (SDGs)** call on “Governments and all stakeholders to take transformative actions, individually and collectively, for people, planet and prosperity, while strengthening universal peace in larger freedom” (UN, 2022, p. 7). The goals were developed over two years of extensive consultation with stakeholders around the world and adopted at the September 25–27, 2015 meeting at the UN headquarters in New York. The 17 goals include global economic, social, and environmental dimensions (see Table 1.1). Now that there are more than eight billion people on the planet, these goals are more important than ever.

Table 1.1 United Nations Sustainable Development Goals

Goal 1. End poverty in all its forms everywhere
Goal 2. End hunger, achieve food security and improved nutrition and promote sustainable agriculture
Goal 3. Ensure healthy lives and promote well-being for all at all ages
Goal 4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all
Goal 5. Achieve gender equality and empower all women and girls
Goal 6. Ensure availability and sustainable management of water and sanitation for all
Goal 7. Ensure access to affordable, reliable, sustainable and modern energy for all
Goal 8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all
Goal 9. Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation
Goal 10. Reduce inequality within and among countries
Goal 11. Make cities and human settlements inclusive, safe, resilient and sustainable
Goal 12. Ensure sustainable consumption and production patterns
Goal 13. Take urgent action to combat climate change and its impacts
Goal 14. Conserve and sustainably use the oceans, seas and marine resources for sustainable development
Goal 15. Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss
Goal 16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels
Goal 17. Strengthen the means of implementation and revitalize the global partnership for sustainable development

Note. From United Nations (n.d.a).

Acknowledged as “a supremely ambitious and transformational vision” with “unprecedented scope and significance” (UN, n.d.b, n.p.), the SDGs officially came into effect on January 1, 2016, with the goal of being accomplished by 2030. Meeting these goals would mean improved health and well-being for people in every corner of the world. The essential role of communication in establishing, maintaining, and promoting the partnerships and infrastructures necessary to accomplish these goals is clear. To show how, we’ll highlight just a few of the success stories as reported in the latest *SDG Good Practices* report (UN, 2022).

- The RecyclesPay Educational Project in Nigeria, run by the African Clean-up Initiative, involves the national, regional, and local governments, the private sector, recycling institutions, local schools, and low-income communities in addressing SDGs 1, 3, 4, 6, 10, 11, 13, 14, 15, and 17. Its main objective is to raise enough money from recycling to pay the school fees of more than 10,000 vulnerable students. One of the enabling factors helping this program is “access to the internet and tech tools for easy communication with beneficiaries and stakeholders” (UN, 2022, p. 29).
- The Deqing County Rural Digital Governance System in the Zhejiang Province of China, run by the Deqing Big Data Development Administration, involves the regional and local governments along with rural communities, including farmers, in addressing SDGs 1, 2, 3, 6, 8, and 9. Its main objective is to improve rural spaces through the use of industry, government, and the rural information structure. Efforts include improving farmers’ digital literacy through, in part, creating “a new carrier for online social communication for villagers” (UN, 2022, p. 32).
- The SINERGI Project in Indonesia, run by the Rajawali Foundation, involves the U.S. Agency for International Development, the Center for Public Policy Transformation, the Central Java Provincial Government, private sector and non-governmental organizations, and youth coalitions in addressing SDGs 4, 5, 8, 10, and 17. Its main objective is to promote coordination among stakeholders to help vulnerable young people living in poverty enter the labor market. When COVID-19 threatened to cripple the project because of reduced availability of low-skilled labor positions, the project team worked with youth to establish “an infrastructure of communication to gather real-time updates on the levels of employment at the grassroots level” (UN, 2022, p. 36).
- The Transforming Exploitation and Saving Through Association (TESTA) program in India, run by the Vilpa Foundation, involves the national, regional, and local governments, police departments, prosecutors, the judiciary, legal services, legal volunteers, social workers, and nongovernmental organizations in addressing SDGs 5, 8, 16, and 17. Its main objectives are to increase the conviction rate for sex trafficking cases in India and to prevent women and girls from being forced into sex trafficking. This project requires immense coordination and communication among numerous operatives involved in stopping sex trafficking, something they achieved by applying a collective impact model to secure a commitment from all involved.

Hundreds of similar projects are being conducted across the globe under the UN’s SGD agenda, and all of them benefit from strategic, coordinated communication among the individuals and organizations involved. The same is true of the communication supporting and promoting the U.S. Healthy People initiative, which has an agenda focused on the health of U.S. citizens.

The U.S. Healthy People Initiative

The **Healthy People initiative** in the United States began in 1979 when U.S. Surgeon General Julius Richmond published *Healthy People: The Surgeon General’s Report on Health*

Promotion and Disease Prevention. In the first chapter of his report, Dr. Richmond noted that improvements to American health would not come from more medical care and spending but “through a renewed national commitment to efforts designed to prevent disease and promote health” (U.S. Public Health Service, 1979, p. 1). An analysis of the factors contributing to the 10 leading causes of death in the United States had revealed that “as much as half of U.S. mortality in 1976 was due to unhealthy behavior or lifestyle; 20% to environmental factors; 20% to human biological factors; and only 10% to inadequacies in health care” (p. 9). Recognizing that prevention reduces healthcare costs, improves the quality of people’s lives, and literally saves lives, Dr. Richmond issued a call “to enhance both individual and national perspective on prevention through identification of priorities and specification of measurable goals” (p. 13). In response, in 1980 the Office of Disease Prevention and Health Promotion (ODPHP) published *Healthy People 1990*, which included “the first set of ambitious, measurable 10-year objectives for improving health and well-being nationwide” (ODPHP, 2021, para. 2). These reports have been updated each decade, making *Healthy People 2030* the fifth iteration of the report.

The goals and objectives of the Healthy People reports have evolved considerably over the years. Whereas the 1990 report focused on decreasing overall death and increasing older adults’ independence, the 2000 report specified three goals: increasing the healthy life span (not just reducing death), reducing health disparities, and increasing access to preventive services. *Healthy People 2010* increased emphasis on improved quality of life and aimed to eliminate health disparities, not simply reduce them. *Healthy People 2020* specified four ambitious goals (ODPHP, 2021, para 5):

- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death
- Achieve health equity, eliminate disparities, and improve the health of all groups
- Create social and physical environments that promote good health for all
- Promote quality of life, healthy development, and healthy behaviors across all life stages

And now *Healthy People 2030* is in place. This latest report “builds on knowledge gained over the last 4 decades and has an increased focus on health equity, social determinants of health, and health literacy—with a new focus on well-being” (ODPHP, 2021, para. 6).

In total, *Healthy People 2030* has 358 core objectives across numerous categories: health conditions (e.g., heart disease and stroke, foodborne illness), health behaviors (e.g., family planning, sleep), populations (e.g., adolescents, people with disabilities), settings and systems (e.g., environmental health, housing and homes), and social determinants of health (e.g., economic stability, neighborhood and the built environment). There are also objectives designated as developmental or research, but it’s the core objectives that are backed by data collected from reliable and valid measures at the national level. This makes it possible to track whether the objectives are being met and where efforts might be falling short. The status of each core objective is reported as (a) having baseline data only, (b) meeting or exceeding the target, (c) improving, (d) having little or no detectable change, or (e) getting worse. We encourage you to visit the Healthy People website to learn the status of the objectives. If you do, you’ll see that progress is being made on many fronts, the result of more than four decades of concentrated effort, but there is a lot more progress that needs to be made.

For progress to happen, there needs to be work on several fronts. We need individuals to modify their health behavior to reduce risk and promote well-being. We need healthcare providers to promote health and prevent, not just treat, diseases and conditions that lead to premature death and chronic illness and disability. We need legislation,

regulation, and social sanctions to make the physical and social environment healthier. And we need to address systemic issues that perpetuate discrimination and lead to health disparities in historically marginalized groups. Furthermore, we need everyone—patients, family members, healthcare providers, allied health professionals, advocates, policymakers, and stakeholders—to understand and appreciate the principles of competent communication and put those principles into practice. And while we’re at it, we need to better educate the public on the benefits of implementing a single-payer, non-profit healthcare system that provides access to care for all Americans—just like every other developed nation.

At the center of all of this is health communication. So, if this book can raise your awareness of health communication research and practice, increase your understanding of how health communication operates in people’s daily lives, and help you take an active role in the promotion of health and prevention of disease, then we, as your textbook authors, will be happy. We also will be happy if you gain an understanding of the discipline of health communication, itself, so let’s turn to that topic now.

Perspectives on Health

A comprehensive perspective on health recognizes that health involves the whole person in their physical and social environments and that multiple factors at both the individual level and systems level influence health and illness.

Healthcare systems of developed nations vary along four core dimensions:

- Whether healthcare providers and payers are private or government-run
- Whether costs are financed through employers/employees, taxes/premiums, or out-of-pocket expenditures
- Whether the systems are non-profit or for-profit
- Whether every citizen is covered or not

The U.S. Healthy People initiative and the United Nations Sustainable Development Goals are national and global efforts to promote health.

An Orientation to Health Communication

In the early 1970s, a small group of communication scholars began meeting at the annual convention of the **International Communication Association (ICA)** to discuss shared research interests in health communication. In 1972, they requested that ICA recognize them as a special interest group called “Therapeutic Communication.” At the 1978 convention, wanting to reflect a broader scope of interest in health beyond therapeutic communication, they voted to change the group’s name to “Health Communication,” and given growth in membership, they were granted division status. Thus, the field was born (Kreps et al., 2022). Today, health communication is one of the most vibrant, complex, and significant areas of research and practice in contemporary society. As many scholars have noted, and as we have already pointed out, health communication affects all persons throughout their lives, whether through interpersonal conversations about health, exposure to health images and information through the workplace or the media, or involvement in the healthcare system. As health issues become more pressing in society, the interest in health communication and the roles for health communication scholars and practitioners will only increase.

Before we get ahead of ourselves, let's tell you what exactly we mean by "health communication." If you scan the literature, you will find several definitions from various sources. We're going to cut to the chase and share the definition we presented in the first edition of this textbook: **Health communication** is the study of messages that create meaning in relation to physical, mental, and social well-being. We derived this definition from two sources. First, the **National Communication Association (NCA)** provides a definition of communication, stating that it is the study of "how people use messages to generate meaning within and across various contexts" (NCA, n.d., para. 1). Central to this definition is the idea that people use messages to create meaning, not simply exchange information. Messages and meanings constitute the heart of communication. Second, our definition is consistent with the WHO (1948) definition of health provided above, which emphasizes physical, mental, and social well-being.

Definition of Health Communication

Health communication is the study of messages that create meaning in relation to physical, mental, and social well-being.

With the definition of health communication in hand, we, as students and researchers, can branch out in all directions. We can consider health communication processes, such as information dissemination, persuasion, and instruction. We can consider the people involved in health communication, such as patients and providers. We can consider goals such as disease prevention and health promotion. And, of course, we can consider communication channels, such as interpersonal communication, mass communication, online information, and social media. We're going to consider all of that and more in this book. We'll be looking at health messages across a variety of contexts, channels, and purposes, and we'll cover the physical, mental, and social aspects of health. In doing so, we're going to be presenting a wide range of theory-driven research from multiple disciplines, including psychology, nursing, medicine, public health, and, of course, communication. As you read about the various studies presented in each chapter, it will be helpful for you to have an understanding of communication as a social science, so let's lay some quick, but solid, groundwork in theory, methods, metatheory, and research.

Some Groundwork in Theory

We'll begin with theory. We've noticed that people in general don't seem to care too much for theory. This could be because they consider being theoretical the opposite of being practical. But Kurt Lewin, a noted psychologist who was one of the "forefathers" of the communication discipline (Schramm, 1997), is known for having said that there's nothing as practical as a good theory. Why is a good theory practical? Because it helps to guide research. Although you could just decide to study some communication phenomenon with no theoretical guidance whatsoever, how would you know where to begin? How would you know what questions to ask? How would you know what's important to look for? How would you make sense of the data you gather? How would you even know what kind of data to gather? You wouldn't. Although atheoretical research can be valuable in a descriptive sense, to be able to make useful contributions to the discipline's knowledge base, it's wise to make use of **theory**, or "an organized set of concepts and explanations about a phenomenon" (Littlejohn, 2001, p. 19).

Table 1.2 Theoretical Frameworks in Health Communication

Theory/Model	Brief Summary	Citation
Communication Infrastructure Theory	An ecological model that describes how communication infrastructures within neighborhoods, called storytelling networks (STNs), influence individual and community-level health outcomes. STNs are composed of community organizations, geo-ethnic media, and neighborhood residents that are situated within a communication action context.	Kim and Ball-Rokeach (2006)
Digital Divide	A gap exists between individuals advantaged by the internet and individuals relatively disadvantaged by the internet because of differences in access and utilization.	Rogers (2001)
Health Belief Model	People's health behavior is influenced by five beliefs (perceived susceptibility to disease, perceived severity of disease, perceived benefits of engaging in the behavior, perceived barriers to engaging in the behavior, and self-efficacy) and motivated by internal and external cues to action.	Rosenstock (1974) and Rosenstock et al. (1988)
Integrated Model of Behavioral Prediction	Attitude toward a behavior, subjective norms about what other people do, and perceived behavioral control predict behavioral intention, which predicts behavior. Skills and environmental constraints moderate the ability of intention to predict behavior.	Fishbein and Ajzen (2010)
Multiple Goals Theory	Conversations involve task, identity, and relational goals, and these goals sometimes conflict. Messages that resolve conflicting goals are more competent than those that prioritize one goal at the expense of others.	Caughlin (2010)

Note. See *Supplemental Online Theory Table* for additional theories/models.

Health communication research is guided by many different theories, which you'll see reflected in the studies we present in upcoming chapters. For now, we want to introduce you to some exemplar theories or models that have informed a great deal of work in the area (see Table 1.2). We'll begin with one of the earliest and most influential: the health belief model. **The health belief model (HBM)** was developed by several social psychologists in the 1950s while they were working for the U.S. Public Health Service (Rosenstock, 1974). They were trying to figure out why people were not engaging in common sense preventive health behaviors, such as screenings and immunizations, even though these services were available at low or no cost. The researchers determined that people's health beliefs played a substantial role in their behavior. In short, the HBM states that people's health behavior will be influenced by four beliefs: *perceived susceptibility* to disease, *perceived severity* of disease, *perceived benefits* of engaging in the behavior, and *perceived barriers* to engaging in the behavior. In addition, internal or external *cues to action*, such as developing a cough or seeing a public service announcement, can motivate behavior. Irwin Rosenstock and colleagues (1988) later added a fifth belief to the model, *self-efficacy*, or a person's belief that they can successfully execute the behavior. According to the model, for people to be motivated to engage in a health behavior, their perceived susceptibility, severity, benefits, and self-efficacy need to be high, and their perceived barriers need to be low. There also should be helpful cues to action to prompt the behavior. Let's consider a hypothetical example to make this a little clearer.

Let's say that Tim and Barry are college roommates. They keep hearing about how everyone needs to keep up to date with COVID-19 vaccines (an external cue to action). Tim thinks he's impervious to disease (low susceptibility) and that if he did catch the virus, it

wouldn't be that bad (low severity). Plus, he thinks the vaccine won't work (no benefits) and it may actually hurt him because the whole pandemic is a government conspiracy anyway (a barrier). Plus, he's not so sure he could track down a vaccination clinic (self-efficacy). Thus, Tim does not get vaccinated. Barry believes the exact opposite of Tim and gets vaccinated and boosted as recommended. Later, Tim starts to notice he can't smell the delicious pizza that Barry brought home for dinner (an internal cue to action). He starts feeling bad and getting sicker by the day (more internal cues to action). Barry finally convinces him to go see a doctor, who diagnoses him with COVID-19. Tim asks for the vaccine at that point, and the doctor says, "That's not the way vaccines work." Whereas Barry's beliefs allowed him to engage in preventive behaviors, Tim's beliefs did not.

The next model we'll discuss is another highly influential one. The **integrated model of behavioral prediction (IMBP)** was developed over many years by Martin Fishbein and Icek Ajzen (2010), and it reflects what is called the **reasoned action approach (RAA)**. The core principles of the RAA are that (a) people's intention to behave precedes their actual behavior and (b) several factors influence intention. Importantly, "reasoned" action in this approach does not mean objectively rational action; instead, people decide for themselves what they think is reasonable on an individual basis. The first version of what ultimately became the IMBP was called the **theory of reasoned action (TRA)**. The TRA said that *attitude toward the behavior* and *subjective norms* about what other people do would predict *behavioral intention*, which then would predict *behavior*. The second version of the RAA was called the **theory of planned behavior (TPB)**. The TPB added *perceived behavioral control*, or the extent to which people believe they have control over the behavior and can accomplish it (basically, self-efficacy), as a predictor of intention. Finally, after years of research using the TRA and TPB, the IMBP was presented as a comprehensive model of behavioral prediction. It added two factors—*skills* and *environmental constraints*—as potential moderators of the intention–behavior relationship (a moderator is a variable that either strengthens or weakens the relationship between two other variables). We'll demonstrate how the IMBP works with a quick hypothetical example.

Jill has decided it's time to start eating healthier. She likes the idea of eating nutritious foods (attitude), most of her friends and relatives eat nutritious foods (subjective norms), and she believes that she'll be able to shop for and cook nutritious foods (perceived behavioral control). So, her behavioral intention is very high. Unfortunately, when she visits her grocery store with an eye toward fresh fruits and vegetables, whole grains, and lean meat and fish, she discovers that the selection is quite limited and the foods are expensive (environmental constraints). She buys what she can afford and brings it home. Her attempt at cooking Brussels sprouts and salmon, though, is a dismal failure (skills). Despite her high behavioral intention, Jill decides she's stuck with processed foods and does not change her behavior.

Next, we're going to move away from models that focus on individual behavior to those that have a more macro-level focus. We'll start with **communication infrastructure theory (CIT)**. CIT is an ecological model that describes how communication infrastructures within neighborhoods, called **storytelling networks (STNs)**, influence individual and community-level health outcomes (Kim & Ball-Rokeach, 2006). STNs are composed of community organizations, geo-ethnic media, and neighborhood residents. They are situated within what is called a *communication action context*, which describes neighborhood characteristics that promote or impede communication within STNs (e.g., resources for families and children, public spaces such as libraries and parks, neighborhood appearance and safety, ethnic and cultural diversity). CIT was originally developed to examine ecological influences on civic engagement, but it evolved to recognize the impact of such engagement on individual and community health. In short, "When a communication action context

facilitates a strong neighborhood STN, positive health outcomes are experienced at both the individual and community level” (Wilkin et al., 2010, p. 611).

Knowing this, researchers have used CIT to guide intervention work to improve the health of individuals and communities across the nation. Holley Wilkin and colleagues (2010) describe several such projects. For example, researchers have developed multiethnic communication maps of neighborhoods in Los Angeles, California to provide information on communication resources to communities. They’ve identified STNs in Atlanta, Georgia to help healthcare providers locate and enroll qualified residents into a healthcare assistance program. And they’ve studied how STNs have helped individuals in Alabama overcome low health literacy by accessing community-level communication resources and protecting themselves during a hurricane by using STNs as a resource for preparedness activities.

The last theory we’ll share is not so much a full-fledged theory (yet) as a concept: the digital divide. The term **digital divide** was coined in the mid-1990s to refer to the fact that there was a gap between people who had access to **information and communication technology (ICT)** and those who did not (Rogers, 2001). This divide raised serious concerns about equity because information and communication underwrite knowledge, and knowledge is power. As digital divide research progressed, the idea of unequal access to technology expanded to include concerns about attitudes toward and motivation to use technology, knowledge and skills to use technology, how frequently and for what purpose technology was being used, and the ability to maintain and update the technology as needed. Several communication theories speak to digital divide concepts, but one that is especially suited is Jan van Dijk’s (2013) **resources and appropriations theory**, which considers the diffusion, acceptance, and adoption of ICTs. The theory’s premises are as follows (van Dijk, 2013, p. 33):

1. Categorical inequalities in society produce an unequal distribution of resources.
2. An unequal distribution of resources causes unequal access to digital technologies.
3. Unequal access to digital technologies also depends on the characteristics of these technologies.
4. Unequal access to digital technologies brings about unequal participation in society.
5. Unequal participation in society reinforces categorical inequalities and unequal distributions of resources.

By *categorical inequalities*, van Dijk (2013) means *personal characteristics* such as age, race, and health (with older, minority, and unhealthy individuals being disadvantaged) and *positional characteristics* such as employment and education (with unemployed or low wage/low skill workers and those with less education being disadvantaged). In short, van Dijk’s theory explains how the digital divide deepens itself through a feedback loop wherein categorical inequalities and unequal distribution of technological resources lead to unequal participation in society, which in turn reinforces categorical inequalities and unequal distribution of technological resources. But how does this impact health? Let’s consider an example of living in poverty during the COVID-19 pandemic.

People living in poverty have fewer resources than others, which means they often have inconsistent access to the internet and other mediated information services, if they have access at all. Throughout the COVID-19 pandemic, national and international guidelines for avoiding infection changed as scientists learned more and updated their knowledge about the virus. These science-based updates were disseminated on credible digital and internet-based platforms. People with access to these platforms would receive this information, but people without access would not. Not having current information could increase the risk of getting COVID-19. If people caught the virus, they might end up hospitalized

and unable to work, possibly even losing their job. With increased medical bills and fewer paychecks, it would be even harder for them to access digital and internet-based platforms to gain information to help keep them healthy and safe. Thus, the cycle perpetuates itself.

Some Groundwork in Methods

Now that your head is sufficiently spinning from theory, it's time for some methods to bring you back down to earth. **Methods** are simply the strategies researchers use to study phenomena of interest. Methods are often grouped broadly into quantitative and qualitative approaches. **Quantitative methods** require data in numerical form so that the data can be analyzed through statistical techniques. The goal of quantitative research usually is to make generalizations about groups of people or phenomena along a set of relevant variables. The variables need to have clear conceptual and operational definitions. A **conceptual definition** describes the meaning of a variable, pretty much like a dictionary definition. An **operational definition** describes how you will measure your variable. For example, if you used the WHO's (1948) conceptual definition of health for a study, you would need to measure physical, mental, and social well-being. **Qualitative methods** require data that allows for in-depth analysis of the socially constructed meanings of language and behavior. The goal of qualitative research usually is to develop a rich understanding of human experiences. Although some scholars will debate the relative merits of quantitative versus qualitative research, a lot of researchers use both methods to provide a more holistic understanding of their topic of study. This approach is called **mixed-methods research**.

Some Groundwork in Metatheoretical Paradigms

In addition to theory and method, researchers also ground their work in metatheoretical paradigms. A **paradigm** is a way of looking at the nature of the social world. We're not going to get into the weeds with this, but we will state that there are three common paradigmatic approaches in health communication research: scientific, interpretive, and critical-cultural. All have merit, and all make important contributions to the body of health communication knowledge. To give you an idea of how, we're going to take a moment to briefly describe each paradigm and present an exemplar study from within the paradigm.

The **scientific paradigm** states that there is one objective reality that exists independent of human beings and that researchers can work without bias to reveal this reality. It doesn't matter that human behavior is complex and each person is a unique individual; there are regularities underlying who people are and what they do, and research conducted from the scientific perspective is out to identify those regularities. As you might expect, scientific researchers embrace quantitative methods such as experimental and survey research and content analysis to gather numerical data that can be analyzed through statistical techniques.

A great example of research that represents the scientific paradigm is a social media study by Nicole Kashian and Susan Jacobson (2020). The researchers were interested in exploring the relationship between engagement in a Facebook support group for Stage IV breast cancer patients, factors related to social media engagement, and health expectations of the members. They used the optimal matching model of stress and social support and the strength of weak ties theory, as well as the construct of perceived homophily, to explore user engagement (as measured by Facebook analytics) and participants' expectations about their health outcomes (e.g., believing they will live longer as a result of participating in the support group). Kashian and Jacobson hypothesized positive relationships between engagement and optimal social support, tie strength, and homophily, as well as between engagement and health expectations, and they posed a research question asking what factors

best predicted engagement. Using content analysis of Facebook posts and anonymous survey data from 74 women who belonged to the private Facebook group, they found support for all hypotheses except the relationship between homophily and engagement, and they found that optimal social support was the factor that best predicted engagement. This study fits the scientific paradigm because of its focus on isolating and assessing how variables are related to one another in predictable and generalizable ways.

The **interpretive paradigm** states that there are multiple subjective “truths” that are socially constructed by humans in everyday interaction and that the researcher plays an active role in constructing these truths. Interpretivist research strives to uncover and understand these subjective, situated meanings of human behavior. Interpretive researchers employ qualitative methods such as interviewing and participant-observation, gathering detailed, descriptive data that they can mine for meaning.

A terrific example of research from the interpretive perspective is a study by Shou Zhou and colleagues (2022) that identified perceived challenges related to COVID-19 prevention and vaccination among ethnic minorities during the pandemic. Guided by the PEN-3 theoretical model, the researchers gathered formative data that could be used to develop a public health campaign to promote COVID-19 prevention behaviors and increase vaccination uptake. They interviewed 18 participants who self-identified as Latino American or Hispanic (LA), African American or Black (AA), and American Indian or Alaska Native (AI/AN), and they identified themes surrounding pandemic-related challenges, perceptions of COVID-19 vaccines, and campaign messaging preferences. They found that participants from all three ethnic groups faced similar challenges related to their social lives and finances as a result of the pandemic, but they also found important differences among ethnicities, such as being particularly concerned about work-related stress (AA) or mental health issues (LA). In terms of perceptions of the vaccines, the researchers found shared beliefs that vaccines could prevent the spread of the virus and stop the pandemic, as well as shared concerns over side effects and how quickly the vaccines were developed, but again, they also found differences among ethnicities, such as concerns about lack of vaccine knowledge (LA), wanting to see public officials and government leaders get vaccinated first (AA), and ensuring equitable access to vaccination (AI/AN). Finally, there were consistent shared beliefs among the different groups about message features that could increase vaccination acceptance and uptake, such as designing positive, prosocial messages that included cultural practices and emphasized protecting family members. Identifying multiple perspectives like these is a primary goal of the interpretive paradigm.

Finally, the **critical-cultural paradigm** is similar to the interpretive paradigm, but it distinguishes itself by its focus on **power**, or the social, political, economic, and cultural means of oppression by the haves of the have-nots. Its methods strive to give voice to people who have been marginalized and to empower them to create social change. In the health communication context, the critical-cultural paradigm forces researchers to question the assumptions they make about what it means to be healthy or sick and who has the authority to say what counts as health promotion or disease prevention behavior (Dutta & Zoller, 2008). Further, it encourages researchers to find ways to change the system to promote greater fairness and equality. #PowerToThePeople!

An excellent example of health communication research from the critical-cultural perspective is work by Comfort Tosin Adebayo and colleagues (2022). These researchers noted that Black women in the United States experience pregnancy-related complications at a significantly higher rate than women of other races and that Black women are three to four times more likely to die from pregnancy-related complications than non-Hispanic white women. Guided by critical race theory, the researchers examined structural barriers within the U.S. healthcare system that limit Black women’s access to quality care during prenatal

and postnatal doctor's visits. For almost a year, the researchers interviewed Black women seeking maternal care in Milwaukee, Wisconsin, which "ranks as the most racially segregated metropolitan city in the U.S." and where "maternal mortality rates were five times higher among African American women compared to non-Hispanic White women in the city" (Adebayo et al., 2022, p. 1138). Following an extensive analysis of their data, the researchers used narratives to highlight problematic experiences of Black women stemming from the white-centric nature of the biomedical model of healthcare, unfair treatment based on health insurance, provider dismissiveness of pain, and the perception of Black women as a charity case. Adebayo et al. note that "Centrally woven throughout the narratives of women in this study is the experience of a racially insensitive healthcare system" (p. 1140). Examining social structures to identify discriminatory systems is a primary goal of the critical-cultural perspective.

The Nature of Health Communication Research

Health communication scholars rely on numerous theories to guide the design of their research studies. They use quantitative and qualitative methods to conduct their research. Research can be conducted from scientific, interpretive, or critical-cultural paradigmatic perspectives. Health communication research can be multidisciplinary or interdisciplinary, and research results can be translated to have a positive impact on the health and well-being of society.

In addition to understanding how theory, methods, and metatheoretical paradigms help to guide health communication research, it's important to appreciate how different academic disciplines contribute to the body of knowledge in health communication and the extent to which they work independently or collaboratively. Health communication is a very broad field, and many researchers from many disciplines have contributions to make. Depending on how they work together (or not) leads to taking a multidisciplinary or interdisciplinary perspective on the research (Parrott & Kreuter, 2011). **Multidisciplinary research** involves scholars from two or more disciplines *independently* investigating the communication dimension of a health problem. For example, researchers from medicine, pharmacy, and communication may each independently study cost-of-care conversations between patients and physicians. In doing so, they'll bring their unique disciplinary knowledge to bear on the research question. Disciplinary knowledge is important, of course, and can certainly offer important and diverse perspectives on a research problem. A completely independent approach, however, especially for complex questions regarding human communication and health behavior, can substantially limit scientific understanding.

This was the conclusion reached by Nancy Harrington and colleagues (2020) in their systematic review of 54 cost-of-care conversation studies. They reviewed this literature to determine (a) how cost-of-care conversations are conceptually and operationally defined in the literature, (b) the extent to which theory was used to guide cost conversation research, (c) the major methodological characteristics of cost conversation studies, and (d) whether findings from the literature could be used to inform the development of communication strategies to guide cost-of-care conversations between patients and providers. After completing their review, they were left with the impression that the literature did not offer an evidence base for developing communication strategies for having effective cost conversations. Instead, the research was heavily descriptive (e.g., results described the length of

cost conversations or whether the patient or physician initiated them) and overwhelmingly atheoretical (only three of the 54 studies were guided by theory).

Harrington et al. (2020) suspected that the reason for this might be that few communication scholars had been involved in conducting the studies. To find out whether their suspicion was correct, they had one of their research assistants track down the educational degrees of the study authors (thanks, Tianen!). He was able to identify the educational degrees of 220 of the 252 authors. How many do you think had PhDs in communication? Four. That's not even two percent. Harrington et al. argued that health communication scholars need to be involved in cost-of-care conversation research teams because their training equips them "to understand the complexities and nuances of message production and exchange in the creation of shared meaning between communicators" (pp. 8–9) and because the communication discipline offers "a wealth of theoretical frameworks that can be brought to bear to help describe, explain, and eventually guide cost conversations" (p. 8). In other words, when studying a communicative behavior, it's advisable to include someone on the research team who is credentialed in the communication discipline. This conclusion highlights the essential role of interdisciplinary research.

Interdisciplinary research involves researchers from two or more disciplines working *collaboratively* to investigate a health problem or the communication aspect of a health problem. The important difference here is that the researchers are working in teams whose members bring different types of expertise to the problem and who can learn from one another to better inform the research. An outstanding example of interdisciplinary health communication research comes from Lauren J. Van Scoy, a medical doctor, and Allison M. Scott, a communication scholar, who began working together to study end-of-life decision making among family members in intensive care units. Van Scoy, a practicing pulmonary and critical care physician, had substantial experience talking to families about end-of-life decisions and had witnessed the exceptional challenges families faced in having these discussions and reaching sound decisions about end-of-life care. She knew that having conversations about a patient's wishes and recording those wishes in a legal document called an advance directive helped patients avoid unwanted care that could prolong unnecessary suffering (see Chapter 8). She sensed that the quality of conversations played a role in making good decisions, yet no matter how much she searched the medical literature, she could find no measure of communication quality, only measures of communication quantity (e.g., number of conversations, length of conversations). Finally, she took a chance and Googled "communication quality measure"—and she found Scott's research on end-of-life conversations.

Scott knew that the research on end-of-life decision making consistently showed that *quantity* of conversations was not related to completing advance directives. She argued that it was conversational *quality*, not quantity, that mattered. Her work was guided by **multiple goals theory**, a theory that explains how people who craft their messages to address task, identity, and relational goals have higher quality communication than those who ignore these goals (Caughlin, 2010). Through extensive observational research with parent/adult child dyads having conversations about end-of-life decision making, Scott was able to demonstrate that the conversations that addressed the task goal of discussing end-of-life decisions, the identity goal of liking and respecting the other person, and the relational goal of affirming the relationship were positively related to satisfaction with the conversation and feelings of hope but negatively related to hurt feelings and relational distancing (Scott & Caughlin, 2014). Subsequent longitudinal analysis showed that such high-quality conversations led participants to have a greater mutual understanding of end-of-life preferences, greater relationship satisfaction and closeness, and a greater likelihood of having completed an advance directive one year after the initial conversation (Scott, 2022).

Van Scoy read all of Scott's research in one night and called her the next day. They've since established a research partnership that has been remarkably successful. They have received