HEALTH COMMUNICATION FOR SOCIAL JUSTICE

A Whole Person Activist Approach

Vinita Agarwal

ROUTLEDGE SOCIAL JUSTICE COMMUNICATION ACTIVISM SERIES

SUPPORT MATERIAL

ROUTLEDGE

"*Health Communication for Social Justice: A Whole Person Activist Approach* resonates with and inspires readers of all scholarly backgrounds. Dr. Vinita Agarwal conceptualizes health and its effective communication in terms of urgent health crises, the lived experiences of health inequity, and the necessity of advocacy."

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"This is a unique textbook for undergraduate and graduate students in the sense that it offers a nuanced approach to understanding health from a wholistic perspective while highlighting the ways in which health plays out for those living at the margins of our society. Theorists and practitioners will find this an invaluable resource."

Ambar Basu,
University of South Florida, USA

Health Communication for Social Justice

This textbook combines whole person and social justice perspectives to educate students on the role of communication in promoting inclusive and person-centered healthcare practices.

This book explores health inequities experienced by disadvantaged and marginalized populations and outlines the actions students can take to address these challenges. The book demonstrates how physical, mental, and emotional health is connected to equitable understandings of individual, community, and environmental health. It considers how social, interpersonal, and systemic factors such as personal relationships, language, literacy, religion, technology, and the environment affect health equity. To present strategies and invite action to support the goals of the whole person, social justice activist approach, the book provides contemporary examples, interviews with communication scholars, and case studies that examine local communities and the everyday contexts of health meaning making.

This textbook serves as a core or supplemental text for graduate and upper-level undergraduate courses in health communication.

Online resources include PowerPoint slides and an instructor manual containing sample syllabi, assignments, and test questions. They are available online at www.routledge.com/9781032081038.

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Health Communication for Social Justice

A Whole Person Activist Approach

Vinita Agarwal

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To my family, Sangeet, Arjun, and Appa, for their unconditional love.

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Foreword

I am very pleased this exciting new book, *Health Communication for Social Justice: A Whole Person Activist Approach*, is now part of the growing and vibrant body of health communication literature. The book makes important contributions to expanding understanding of the relevance and intricacy of health communication in modern life. The whole person healthcare approach (that is highlighted in the book) clearly describes the multiple interdependent communication factors that are at work in the delivery of care and promotion of health, including how powerful underlying cultural norms influence health beliefs, expectations, and actions that are unique to each person. The book shows that we each are products of the different intersectional cultural communication experiences that have continually shaped and continue to reshape the ways that we make sense of and react to health and illness.

To help people productively adapt to the serious health challenges they experience, this book helps us understand how individual unique cultural perspectives demand culturally sensitive and responsive health communication. This underscores the need to gather information from those who are confronting health problems to learn about their most memorable and influential personal (and observational) experiences with health and illness that shape their responses to health challenges. The book also illustrates the need to communicate strategically in the delivery of healthcare to elicit information about the variety of health issues that individuals are most concerned about so we can help them address these concerns with appropriate care and health promotion activities. The book suggests that the best healthcare communication is person-centered, speaking to each person's individual health history and sharing information to engage each person (and often members of their social networks) in participating in healthcare and health promotion activities.

The important information presented in this book is directly relevant to everyone who confronts personal health challenges (which basically includes all of us!) to help promote individual health and well-being. It is relevant to everyone who delivers healthcare services and advice (which includes more than just trained healthcare professionals since the vast majority of healthcare services are provided outside of formal healthcare facilities by personal connections, by our family members, friends, and colleagues). It is relevant to healthcare team members who need to share relevant information with each other to promote collaboration for making the best possible health decisions. It is relevant to health educators who provide needed guidance to healthcare providers and consumers about health risks and response strategies. The information in this book is also relevant to health system policymakers to

guide their important decisions about establishing and refining effective guidelines for delivering care and promoting health.

It is my hope that many people will use the powerful information in this book to help them strategically use communication to promote their own health and enable them to help others achieve their health goals too!

Gary L. Kreps, PhD
George Mason University

Preface

Health Communication for Social Justice: A Whole Person Activist Approach

Focus and Scope

Talking about health communication in everyday contexts has never been more important. From determining the credibility of the daily barrage of health information and suggestions that people receive from media sources and campaigns conducted by organizations, to knowing how to engage in social interactions that ensure equitable and accessible opportunities for health, health communication embeds every facet of people's lives. In whole person healthcare (hereafter, WPHC), people are seen as individuals who are embedded in social relations, leading to healthcare that is grounded in their unique values, needs, and goals. WPHC invites us to consider the facets of an individual's circumstances that impact healthcare conceptualization, delivery, and outcomes from a social justice (SJ) lens. These include the individual's family, community, and other relationships and resources; the environment and how it shapes their lived contexts and those of the species that share our planet; provision of clinical follow-up on their health needs; their religious and spiritual beliefs and how these are addressed in healthcare settings; wellness education and treatment support; and coordination of care to reduce Medicare or Medicaid expenses, urgent care, and emergency department visits and hospitalization outcomes and costs. WPHC accounts for the individuals' diet, exercise, and healthy relationships as the foundation of well-being, ensuring food security, mobility, high-touch care, and virtual health coach visits. WPHC, thus, considers the many individual, institutional, policy, environmental, global, religious, and social factors that affect people's health.

The textbook will delve into each of these facets in detail. It will provide an insightful, comprehensive, and action-oriented look at how each facet shapes WPHC and how we as individuals, caregivers, community members, and critical healthcare consumers and producers, can intervene to make WPHC equitable, inclusive, and accessible for all. The textbook is unique in centering multiple forms of intersectionalities through the social determinants of health (SDoH) perspective with respect to whole person and social justice activism (SJA). Chapters include ample instances and discussion of intersectionalities (e.g., race and gender and ability status) both in pedagogical features and chapter content. Social movements, and the political, ideological, and social-historical contexts underlying these topics are central to describing WPHC and its SJA intersections.

Main Themes and Objectives

Health Communication for Social Justice: A Whole Person Activist Approach helps students to:

- Know and attend to the many types/forms of health (e.g., physical, mental, and spiritual) and health contexts and interactions (e.g., interpersonal, group, organizational, institutional, societal, and global) when a whole person approach is adopted.
- View health through a SJ lens to identify and address health inequalities/disparities (e.g., access) that affect members of oppressed communities.
- Identify the different healthcare models in use and their comparative strengths in WPHC.
- Understand how we communicate and think about health shapes our health outcomes in relationship with others.
- Understand how individual health is intricately connected with social, global, religious and spiritual, and environmental health.
- Examine health communication in everyday life from diverse perspectives.
- Understand how evolving communication technologies can contribute to achieving holistic, socially just healthcare.
- Engage in communicative action to achieve the goals of the whole person, SJ approach to health.

Organization and Rationale

The textbook is organized around three sections:

I. **Conceptualizing Health**: This section introduces *how we theorize health*. The three central themes of the textbook are *whole person* and *SJA* framework within a *social constructionist* approach to health. Thus, the three chapters that discuss frameworks for these themes are placed in this section.
II. **Constructing Health**: The second section emphasizes the *constructed nature of health and health-related meaning making*. This emphasizes how the WPHC SJA is based on health-related meaning making in *situated*, *historical*, *political*, *social*, *and economic contexts*. The chapters on *evolving understandings of health*, *healthcare relationships*, *healthcare systems*, and *health literacy* are placed here.
III. **Contextualizing Health**: This focuses on the *contexts in which health practices are enacted and health communication occurs*. The contexts in which health-related meaning making occurs and in which health practices are enacted shape our conceptualization and construction of health. These factors provide a point of entry to discuss SJ principles (e.g., equity, access, and fairness). The chapters on *health and the environment; technology and health; health, religion, and spirituality*; and *global health* are placed here.

Significance

Finally, the significance of enduring structural change is knit through the chapters in numerous discursive and organizational ways through the *pedagogical features* and *chapter content*. Each chapter includes ample provocative and intervention-oriented material with the following features: chapter organization; communication scholar(s) interviews work that connects their research to a whole person, social justice context; textboxes and table(s) with theories,

definitions placed in engaged, applied contexts, resources, and SJA prompts and activities; discussion questions and thought scenarios for student reflection; present challenges and future directions exercise for students; and reference list of sources cited in chapters, along with helpful sources in each textbox. Together, the textbook provides the conceptual foundations and action-oriented lens to achieve a whole person vision of health.

Acknowledgments

I would like to thank my publishing team at Routledge, especially Alexandra de Brauw, commissioning editor, and Sean Daly, editorial assistant, for their invaluable guidance; series coeditor Dr. Larry Frey, for the invitation to write the textbook; Fulton School of Liberal Arts dean, Maarten Pereboom, for his support of the effort; and my students, who inspire and guide the way we will tread the path of justice and health for those who need it most in the present and the future.

Selected Abbreviations

AI	Artificial intelligence
ACA	Affordable Care Act
ADA	Americans with Disabilities Act
AHRQ	Agency for Healthcare Research and Quality
AMA	American Medical Association
BM	Biomedical model
BSM	Biopsychosocial model
CAM	Complementary and Alternative Medicine
CBC	Community-based care
CBPA	Community-based participatory approach
CBPR	Community-based participatory research
CDC	Centers for Disease Control and Prevention
CHC	Community health center
CIM	Complementary and Integrative Medicine
CMS	Centers for Medicaid and Medicare
COPD	Chronic obstructive pulmonary disease
CPE	Clinical pastoral education
CVD	Cardiovascular disease
DC	Diagnostic care
EHR	Electronic health record
EM	Ecological model
ER	Emergency room
FCC	Federal Communications Commission
FCH	Family cancer history
FDA	US Food and Drug Administration
FHH	Family health history
GHSA	Global Health Security Agency
HH	Health humanities
HHC	Home healthcare
HHS	US Department of Health and Human Services
HINTS	Health Information National Trends Survey
HM	Holistic model
HRSA	Health Resources Services Administration
IM	Integrative medicine
IOM	Institute of Medicine

IPC Interprofessional communication
IPCC Intergovernmental Panel on Climate Change
LMIC Low- and middle-income countries
NCD Noncommunicable diseases
NCI National Cancer Institute
NLM National Library of Medicine
NNLM Network of the National Library of Medicine
NP Nurse practitioner
NTD Neglected tropical diseases
PA Physician assistant
PC Primary care
PCC Patient-centered communication
PCP Primary care providers
PHI Personal health information
RC Rehabilitative care
RHM Rhetoric of health and medicine
SC Secondary care
SCoH Social construction of health
SDoH Social determinants of health
SDG Sustainable Development Goals
SJ Social justice
SJA Social justice activism
SM Social mobilization
SUD Substance abuse disorders
TC Tertiary care
UN United Nations
WHO World Health Organization
WPHC Whole person healthcare

Section I

Conceptualizing Health

Chapter 1

A Whole Person Framework of Health

Chapter Learning Outcomes

Upon completing **Chapter 1, A Whole Person Framework of Health**, the student should be able to apply **whole person health communication** (WPHC) **social justice activism** (SJA) principles to:

1. Explain the tenets of a WPHC framework from the perspective of the individual, the healthcare provider, and healthcare systems.
2. Explain how health can be understood from a social constructionist perspective and seen as relational, interdependent, and reflexive.
3. Understand how the WPHC includes complementary and integrative medicine (CIM) approaches in the conceptualization and delivery of care.
4. Identify how the social determinants of health (SDoH) contribute to health outcomes for individuals from diverse backgrounds.
5. Explain how the WPHC framework supports an inclusive and rights-based approach to health.

Consider the following contexts:

Social isolation, understood as a lack of social connections and interactions (see, e.g., House, 2001), can have significant effects on an individual's health and well-being. The US Surgeon General's Advisory underscores the urgency of attending to the public health crisis of loneliness, isolation, and lack of connection in America (The US Surgeon General, 2023). The report highlights the implications of social media use on adolescents' social, educational, psychological, and neurological development. Social media usage does not occur in isolation; rather, it involves the larger domain of stakeholders ranging from local and national public policy, health professionals, systems, and relationships; researchers and educators; workplaces; community-based organizations, technology, media, and entertainment industries, parents caregivers; and individuals. Young adults with high social media usage, measured as time and frequency of use, for instance, demonstrate higher degrees of social isolation (Primack et al., 2017). On the other hand, because many socially isolated people use social media, social media platforms offer a useful venue for

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intervention. Social media platforms, including Facebook, X (formerly known as Twitter), YouTube, LinkedIn, Instagram, and Snapchat, whose usage is prevalent among young adults, offer an opportunity to mediate social isolation and aggravate it.

Social isolation among vulnerable populations such as older adults can increase the risk of experiencing chronic health conditions that include cardiovascular disease, type 2 diabetes, chronic stress, depression, and anxiety (Lubben, 2017; Nicholson, 2012; Tomaka et al., 2006). The negative effects of social isolation on older adults' physical, mental, and emotional health are especially severe for those who have limited mobility, do not engage in daily physical activity engagement, and/or are managing multiple chronic health conditions. Moreover, the deleterious effects of such forms of social isolation accumulate over a lifetime (American Psychological Association, 2021; Taylor et al., 2019). Social isolation, thus, is a public health issue. The American Association of Retired Persons (AARP) Foundation (2016) reported that social isolation is a growing epidemic in the United States affecting more than eight million older adults. Social isolation can lead to loneliness, or a negative feeling of being alone or separated (National Institute on Aging, 2021). However, people with many social contacts can also feel lonely and socially isolated, and those with few social contacts can feel socially connected (Cacioppo et al., 2009, 2011). Hence, whether people feel socially isolated or socially connected is not about the number of social contacts but about how people see and feel about their relationships with those in their social network.

Research indicates that African Americans, compared to non-Hispanic Whites, are less likely to live alone. However, factors such as race-related stress, stemming from older African Americans' distrust of healthcare providers, can contribute to an increase in their social isolation, putting them at increased risk of myriad negative health outcomes (Cornwell et al., 2008).

Social isolation is a complex mental health issue. For those who are vulnerable, thoughtful engagement on social media can enhance self-worth, connections, and well-being. Such usage can help address the public health crisis stemming from bullying, prejudice, and exclusion that can aggravate mental health challenges, societal violence, and the potential for self-harm.

Chapter Organization

Chapter 1, A Whole Person Framework of Health, is organized as follows: **First**, the chapter conceptualizes the WPHC approach, focusing on how health is an individual and collective concern, and teases out the distinctions between health, illness, and disease. It situates the WPHC framework with the value-based ethic of care in relationship with CIM, coordination of care, and preventative care as a socially constructed concept. **Second**, the chapter connects WPHC as centrally connected with the tenets of **social justice** (hereafter, **SJ**) by explaining how the SDoH contribute to inclusive health outcomes and the relational and socially constructed nature of health. **Third**, the chapter considers the WPHC as an inclusive approach with a rights-based approach to health framework. **Fourth**, the chapter concludes with a discussion of how WPHC's "health-for-all" philosophy is an SJ-rights-based approach to health. Along the way, the chapter will **present applied WPHC contexts** and **SJA discussion prompts**

and activities ranging from mental and physical health challenges faced by individuals who identify as LGBTQIA+ to the WPHC model in clinical settings, healthy neighborhoods, substance abuse disorders, and SDoH-related racial disparities in cardiovascular diseases. The communication **scholar interview** with Dr. Gary L. Kreps, foundational scholar of health communication, presents his research and advocacy in the domain of the WPHC approach to health. Students are invited to engage in **actionable ways** with the SJA dimensions of each WPHC context to intervene, advocate, promote, or increase awareness of the concepts with each activity. The chapter concludes with the **present challenges and future directions exercise** on going out into the field and involving community members to identify barriers and organize collectively for crafting communicative avenues for change.

Conceptualizing WPHC

The COVID-19 pandemic led to the implementation of social isolation policies to limit the spread of the virus. Virtually everyone, from very young children to older adults, struggled with adapting to the unprecedented quarantining and social distancing measures. For instance, Berg-Weger and Morley (2020) found that during the pandemic, older adults experienced an acute sense of social isolation and loneliness, resulting in increased depression, anxiety, and financial challenges. However, they also discovered an unexpected positive aspect of the pandemic: people of all ages who experienced social isolation increased their awareness of its negative effects on their health. Because of that increased awareness, Berg-Weger and Morley argued that people are now aware of the need to address the effect of social isolation on health for members of vulnerable populations, such as older adults.

The WPHC Approach

Health as an Individual and Collective Concern

Good health is integral to people's well-being and quality of life. Any time that people's health is negatively affected, it has an immediate and indirect impact on their daily well-being. It is, therefore, important to understand how people make meaning of health, sickness, well-being, and malaise, as well as the distinction between illness and disease. Moreover, health-related concerns are not just limited to the individuals who experience them; as the COVID-19 pandemic has demonstrated, individuals' health is intimately and powerfully connected with the health of their family members and friends, the communities and society in which they live, and the planet. Health, thus, is both an individual and a collective issue.

Health, Illness, and Disease

The WPHC approach views health not just as a physical condition but as a combination of physical, mental, social, relational, spiritual, and other aspects that a "whole" person experiences. Health is defined by the World Health Organization (WHO) as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (2021b). That definition is in line with medical philosophers who have argued that health is more than the absence of disease. Rather, this definition of health emphasizes the ability to assimilate the experience of disease and illness in an individual vision of health. An illness emphasizes people's perceptions of a health condition they (or others) experience, such as pain, discomfort, or fatigue. (Boyd, 2000). A disease is understood as an objectively measured deviation from a biological norm. In contrast to an illness, which people manage themselves

at home, a disease often requires medical intervention and treatment in clinical settings. In making sense of disease, illness, and health, therefore, people rely upon value judgments to determine their meaning in individual contexts. The WPHC considers the patient as an individual with a body, emotions, thoughts, beliefs, hopes, and desires.

Defining the WPHC Framework of Health

This section provides a brief look at WPHC through a systemic and individual lens. It situates the WPHC framework in alignment with the biomedical approach to health and describes the concerns of value-based care. **Chapter 2, Models for Representing Health and Disease** will provide a more detailed look at the biomedical model of care along with the biopsychosocial model of health, integrative care model, and holistic care model. **Chapter 6, Healthcare Systems** will discuss the premise of value-based care in greater detail.

WPHC

The WPHC is concerned with the health of the "whole person," which includes physical, emotional, mental, spiritual, and psychosocial facets, along with the context in which individuals construct the meanings of health. In WPHC, the contextual dimensions of people's lives can range from the health of their interpersonal and group relationships and physical environments in which they live to the health of their communities and society, writ large. Conceptualization and delivery of WPHC, therefore, must address the many health dimensions of people's lives.

WPHC in Comparison with Biomedical Approach

The biomedical approach understands disease one organ system at a time, with health and disease considered to be two separate states (Langevin, 2020). WPHC references care for the whole person rather than focusing on a single diagnosis or health condition. WPHC is, thus, patient-centered and uses diverse healthcare resources to deliver all aspects of care in a whole

Figure 1.1 Whole person health includes physical, mental, spiritual, and psychosocial facets.

person context. In clinical contexts, WPHC is seen as being multidimensional, emphasizing coordination of care, recognizing the physicians' humanity, highlighting the therapeutic relationship between the patient and the provider (Agarwal, 2018a, 2018b, 2019), recognizing healthcare recipients' personhood, viewing health as more than an absence of disease, and employing a range of CIM treatment modalities (Thomas et al., 2018).

WPHC and the Shift to Value-Based Care

WPHC centers value-based care by prioritizing coordination of care at multiple levels. The levels of care can range from primary care (e.g., the primary care physician), secondary care, tertiary care, and quaternary care (see **Chapter 6, Healthcare Systems**, for the different levels of care) and range from the primary care physician to specialists, community-based care, and CIM approaches. WPHC seeks to ensure that individuals receive comprehensive and integrative care in a cost-effective manner. By emphasizing coordination of care, WPHC seeks to address the complexity of an individual's health needs important for clinical and self-management in multimorbid disease domains like chronic conditions in a manner that leads to optimum health outcomes. Chronic conditions like hypertension, diabetes, osteoarthritis, and chronic obstructive pulmonary disease (COPD) are often characterized by multimorbidity and require coordination of care across primary care services, specialist care, medication use, hospital admissions, and community-based care (Ellner & Phillips, 2017). For instance, individuals with type 2 diabetes will also often have comorbidities including hypertension, obesity, hypothyroidism, and dyslipidemia. Multimorbidity is characterized by the presence of two or more chronic conditions in an individual at the same time.

THE SHIFT TO VALUE-BASED CARE

The systemic shift to value-based care sees healthcare recipients as individuals whose health status should be interpreted as a confluence of the socioeconomic circumstances that may make them vulnerable to specific health risks. Value-based care emphasizes the need to address population health in an optimal, cost-effective manner, particularly for high-risk groups. Communication, coordination, and collaboration are considered the three key components of WPHC. Value-based care is discussed in greater detail in **Chapter 6, Healthcare Systems**. To deliver value-based care, WPHC institutions strive to integrate behavioral health services into every healthcare recipient's experience and to treat both their physical and behavioral health needs. Behavioral health services are often delivered in community-based settings and include mental health treatments, addiction counseling, and preventative care. In WPHC, healthcare delivery is also integrated into community settings to span the continuum from inpatient operations to outpatient operations and community outreach.

CHALLENGE TO WPHC

One challenge that WPHC faces at the systemic level is that not all the care components (e.g., CIM approaches) are covered by healthcare insurance. That lack of health coverage poses a challenge for members of marginalized and vulnerable populations to access preventative and health promotion services. Unlike biopsychosocial care, that lack of insurance coverage also poses challenges for the providers who utilize an integrative care model to provide better patient care.

*Review **Textbox 1.1** for a look at the key conceptual terms and their meanings.*

Textbox 1.1 A Whole Person Framework of Health

WPHC Context

The five domains below reference key conceptual domains in the WPHC framework and their meanings.

WPHC is care that is:

- **Multidimensional**
  Health comprises the physical, mental, social, relational, environmental, and spiritual aspects that make up a whole person.
- **Subjective**
  Health outcomes go beyond the physical body to understand how our feelings, emotions, thoughts, and beliefs play into our perceptions of being healthy.
- **Person-centered**
  Health is person-centered, seeking to meet individuals' physical, emotional, cognitive, sexual, occupational, social, and existential needs.
- **Value-based**
  Looks at patients as individuals whose health status should be interpreted as a confluence of the socioeconomic circumstances that may make them vulnerable to health risks.
- **Integrative**
  Hospitals and health systems focus on integrating behavioral health services into every aspect of patient care, as well as coordinating and connecting with community resources.

SJA Discussion Prompt

Individuals who identify as LGBTQIA+ populations are at risk of poorer mental and physical health as compared with individuals from heterosexual and cisgender populations. These poorer health outcomes are often related to barriers in the healthcare system that perpetuate these health inequities. Healthcare factors such as a distrust of the healthcare system and discriminatory experiences by healthcare providers can exacerbate these concerns. The concerns are also exacerbated by the intersection of race and ethnicity, geographic region, and socioeconomic factors. Some of the domains of health disparities evidenced in the LGBTQIA+ populations include a higher rate of mental health concerns, substance abuse, risky sexual behaviors, self-harm, and suicide.

Consider the WPHC concepts of healthcare as multidimensional, subjective, person-centered, value-based, and integrative.

1. What advice will you give nurse practitioners and healthcare providers from the perspective of the WPHC framework of health to ensure their communication with LGBTQIA+ is inclusive and culturally sensitive?
2. Design one recommendation to help healthcare providers engage in gender-affirming communication that encourages recognition of the barriers and challenges faced by individuals from this population.

Resource

Medina-Martínez, J., Saus-Ortega, C., Sánchez-Lorente, M. M., Sosa-Palanca, E., Garciá-Martínez, P., & Mármol-López, M. I. (2021). Health inequities in LGBT people and nursing interventions to reduce them: A systematic review. *International Journal of Environmental and Public Health*, *18*(22), Article 11801. https://doi.org/10.3390/ijerph182211801

WPHC and Integrative Medicine

The integrative medicine (IM) model promotes health by emphasizing the balance between the body, mind, and spirit through evidence-based complementary and alternative medicine (CAM) approaches and conventional medicine. WPHC approaches are employed by providers working in IM healthcare settings, which focus on value-based healthcare and offer holistic treatment for people's long-term physical and mental health. IM combines WPHC value-based and CIM approaches to address the multiple dimensions of whole person care, including people's bodies, minds, emotions, and spirits. The goal of WPHC is to apply scientific and technological advances in healthcare to address the mental and spiritual aspects of well-being that play an important part in health-related meaning making and outcomes.

Review ***Textbox 1.2 Scholar Interview*** *with* ***Dr. Gary Kreps****, one of the earliest founders of the field of Health Communication, and a recognized scholar-advocate of the WPHC framework*.

TEXTBOX 1.2 Scholar Interview

Dr. Gary L. Kreps
University Distinguished Professor and Director of the Center for Health and Risk Communication, George Mason University

1. What does the "whole person healthcare" (WPHC) approach mean to you? How is WPHC relevant in the current sociopolitical context?

   The WPHC approach illustrates how multiple powerful factors influence health promotion, healthcare, and health outcomes. The approach examines the ways that many different societal and cultural communication factors influence health, such as the unique ways that individuals and collectives create meanings to make sense of health and illness, such as the ways that communication can influence our emotions, beliefs, levels of understanding, anxiety, uncertainty, confidence, comfort, and faith related to health and healthcare. Symbolic aspects of health guide the ways we respond to health problems. We are directly influenced by the health communicative practices that we engage in. For example, the use of validating health communication from significant others (including healthcare providers, family members, romantic partners, friends, and community leaders) concerning health issues can provide us with the needed support, encouragement, and direction to help us address challenging health risks we may face. While the lack of supportive and validating health communication can often discourage people from disclosing their health concerns, actively seeking needed care, and engaging in health-promoting activities. WPHC illustrates that the influences of health communication in different social contexts,

cultural groups, personal relationships, and organizations can have strong influences on important health outcomes. This suggests that health communication research and practice must address the variety of key sociopolitical and ecological health communication factors that are directly related to promoting health and well-being.

2. Your work has advocated for communication to promote justice in the healthcare system. What advice would you offer those who would like to apply the WPHC approach to advocate for social justice?

   The WPHC approach suggests the need to carefully examine how access to relevant health information and support within unique social systems can influence health outcomes. To promote justice in the healthcare system we need to develop communication programs, policies, practices, and technologies that fit the unique needs, expectations, and perspectives of different individuals and groups. The WPHC approach also suggests the need for conducting community-based collaborative research and intervention efforts that work closely with members of different at-risk communities to address serious health issues and risks they face.

3. How can health communication professionals employ the ethos of the WPHC approach to advocate for equitable health outcomes for minorities and marginalized populations?

   Health communication professionals interested in promoting equitable health outcomes for marginalized populations can use the WPHC approach to guide their multimethodological community-based research efforts to help identify the unique interrelated factors that lead to poor health outcomes for different individuals and groups. Data from such research can guide the design and implementation of culturally sensitive communication interventions, programs, policies, and technologies to address health disparities.

4. In your point of view, what is one particularly good example of a community-based application of the WPHC approach that promotes social justice?

   The INSIGHTS (International Studies to Investigate Global Health Information Trends) research consortium program that I coordinate uses the WPHC approach to promote social justice, by collecting revealing data in multiple countries about serious gaps in health information access and use faced by different population segments. The data from this research can be used to guide the development of evidence-based, social justice communication intervention strategies to provide at-risk populations with needed information and support, both within each country and across countries.

Coordination of Care in WPHC

The WPHC approach is patient-centered and emphasizes the allocation and coordination of multiple resources such as behavioral, physical, and social support in the care of the whole person. Coordination of care involves the seamless sharing of patient information and health status across all healthcare provider domains involved in patient care with the goal of achieving optimal health outcomes and cost efficiencies. The WPHC approach sees individuals' medical information as being an important, but incomplete, part of their health story. Along with clinical care, the WPHC also considers intersections of care such as how an individual may get to the physician's office and access care.

The Individual's Health Story

Aspects of individuals' complete health picture will include their lived contexts, such as where they live. For example, the health picture will consider where they live (i.e., whether they live in a disadvantaged neighborhood, e.g., one with poor access to healthy food sources or health services), their race, their socioeconomic status, their ethnicity, the language they speak, their religious values and beliefs, housing stability, food insecurity, and cultural practices. By thinking of health and disease as two ends of a continuum and not two distinct and isolated concepts, the WPHC approach shifts attention from the clinical disease symptoms to encompassing people's lifestyle and belief-related health behaviors, such as, for instance, their poor diet, sedentary lifestyle, chronic stress, and poor sleep. Thus, WPHC is whole person centered in its conceptualization of health, illness, and disease.

Supporting a Preventative Approach

Addressing lifestyle and belief-related health behaviors can prevent chronic health conditions, such as diabetes, cardiovascular disease, degenerative joint disease, and depression. In turn, recognizing health and disease as being on a continuum can lead to achieving better health outcomes by taking a preventative approach and addressing these behaviors at an early stage to prevent the occurrence of multiple diseases down the line. A range of behavioral health statistics, from mental illness to substance use disorders, are essential for effective, integrated care.

Creating a Continuum of Care

In WPHC, healthcare systems integrate behavioral health services into every aspect of people's healthcare, as well as coordinate and connect health recipients with community resources that can help them. This coordination and connection of care supports the goal to create a continuum of care that reflects integration at each point on the road to accomplishment of overall good health (American Hospital Association [AHA], 2021). The type of integrated healthcare that the WPHC approach offers is needed in myriad healthcare contexts, from cardiac rehabilitation to breast cancer survivorship care. WPHC approaches may include community-based whole-health systems, such as Ayurveda and Traditional Chinese Medicine (TCM), and integrated complementary and conventional, biomedical, and biopsychosocial approaches.

Review ***Table 1.1 The Whole Person Model of Care in Clinical Settings****.*

The information under the column "Clinical Contexts" provides an illustrative example of one clinical context for patient care.

The information under the column "WPHC Component: Healthcare Settings" provides examples of WPHC components of care in healthcare settings.

The information under the column "WPHC Component: Community-Based Settings" provides examples of WPHC components of care applicable to that clinical setting.

The information under the column "WPHC Component: CIM Settings" provides examples of CIM modalities as applicable to a WPHC framework of care in that clinical setting. Respond to the SJA prompt that follows.

Table 1.1 Whole Person Model of Care in Clinical Settings

Clinical Contexts	*WPHC Component: Healthcare Settings*	*WPHC Component: Community-Based Settings*	*WPHC Component: CIM Settings*
Oncology	Care coordination includes: • Physicians • Nutrition therapists • Psychotherapists • Clinical social workers • Genetic counselors • Pharmaceutical experts	• Personalized care by a team of professionals • Convenient access to ancillary support services (e.g., financial counselors)	Combined with evidence-based CIM therapies to care for the whole person through: • Exercise • Nutrition • Yoga • Acupuncture for pain management • Mental health • Chemotherapy side effects • Post-surgical recovery support
Chronic Pain	Multidisciplinary rehabilitation including: • Patient counseling • Health coaching • Psychiatric care • Behavioral health therapy • Functional medicine combining illness coping and pain management.	Community-based education that includes: • Exercise self-management programs • Social network support • Patient expertise and preferences • Patient empowerment	Includes CIM approaches such as: • TCM Acupuncture • Yoga therapist • Tai chi
Substance Abuse	Addresses people's multiple needs tailored to their age, gender, ethnicity, and culture, including: • Medical Psychological • Social • Vocational • Legal • Cognitive behavioral therapies • Medication management • Detoxification • Individual, family, and group therapy • Personal training and cardiovascular exercise	Care coordination programs that: • Provide appropriate levels of funding support. • Assess need for mental health and substance abuse disorder treatment and services. • Make referrals to programs to match treatment and service needs to facilitate substance abuse disorder prevention, treatment, and recovery.	Include CIM therapies such as: • Animal assistance • Arts programs • Sports • Spiritual instruction Acupuncture • Meditation

SJA Prompt

For each of the three illustrative clinical contexts provided in Table 1.1, oncology, chronic pain, and substance abuse, consider the contribution of an individual's lived contexts such as neighborhoods, education, or financial stability (these will be captured by the SDoH, discussed in a later section) toward successfully achieving the goals of WPHC:

1. Identify one key attribute of the individual's lived context that seems specifically relevant to each clinical context.
    a. Is it easy to identify just one?
    b. Would you need to include more than one facet of the individual's lived context?
2. What factors went into your decision to include that one key attribute and not another?

WPHC and the Transactional Healthcare Model

WPHC as Distinct from the Transactional Model

The WPHC approach differs from the transactional healthcare model, which sees disease in isolation from the whole person. Shifting from a transactional model to a value-based WPHC approach has affected chronic condition management in vulnerable populations, where many whole-health factors affect individuals' ability to achieve and maintain optimal health and well-being.

For example, in a transactional model, people who have diabetes need to coordinate interaction with their primary care physician (PCP), optometrist, and podiatrist individually. If the PCP performed blood tests, those results would not automatically be shared with those other healthcare providers. Moreover, those healthcare providers would not discuss certain topics that are the province of the other healthcare providers; for instance, the PCP would not discuss with their patient that person's mental health.

WPHC in Comparison with the Transactional Model

The WPHC approach coordinates people's healthcare with respect to all their healthcare providers and the behavioral health and social services they are receiving. For example, a person experiencing a chronic health condition might see a dentist, who may identify an underlying pathology and share their report with the person's PCP, enabling timely preventative treatment. Using WPHC, people who are at high risk of experiencing chronic health issues with high comorbidity, thus, receive more sustainable health outcomes and, ultimately, effective healthcare.

SDoH in WPHC

One way to identify the many intersecting factors that contribute to an individual's health is by using the SDoH framework. SDoH, according to The Centers for Disease Prevention and Control (CDC, 2021), are the "conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of-life risks and outcomes." The WHO (2021a) noted that SDoH capture the way the "distribution of money, power, and resources at global, national, and local levels" impact individual health outcomes. SDoH relate to the myriad aspects that comprise an individual's life, ranging from personal safety and mobility to violence prevention, urban health, and healthy aging as they affect individual health, and reflect social inequities experienced at local, national, and global levels. In this manner, they cross different sectors such as education, infrastructure, environment, and places of employment. Thus, addressing SDoH to achieve WPHC is a multisectoral endeavor that requires cooperation across healthcare agencies and a sustained focus on the interrelated factors that shape people's living conditions.

Domains of SDoHs

Healthy People 2030 is a national public health initiative that seeks to highlight public health priorities that need attention in the coming decade. Healthy People 2030 identifies five key areas of SDoHs: "(a) healthcare access and quality, (b) education access and quality, (c) social and community context, (d) economic stability, and (e) the neighborhood and built environment." These domains are described as follows:

Healthcare Access and Quality

This domain describes the "connection between people's access to and understanding of health services and their own health" (Health.gov, 2023) Factors affecting that **connection** include whether and the extent to which people have healthcare insurance, available primary care, and their health literacy (the ability to understand and to use information about their health conditions to make informed decisions).

Education Access and Quality

This domain refers to the "connection of education to health and well-being," and is assessed regarding enrollment in high school or in an institution of higher education, language literacy, and early childhood education and development.

Social and Community Context

This domain describes the "connection between characteristics of the contexts within which people live, learn, work, and play, and their health and well-being." That area includes, among other things, the cohesiveness of people's relationships and the geographical community, their participation in civic life, workplace conditions, and whether they have been incarcerated.

Economic Stability

This domain connects "the financial resources people have—income, cost of living, and socioeconomic status—and their health" (CDC, 2023).

Neighborhood and Built Environment

This domain describes the relationship "between where a person lives—housing, neighborhood, and environment—and their health and well-being" (Health.gov, 2023).

*Review **Textbox 1.3 Healthy Neighborhoods**. As you consider the different facets of a healthy neighborhood and their impact on residents' health, imagine what a whole person approach to designing a healthy neighborhood would look like.*

How would it approach a neighborhood that supports a health-relevant social, built, and land use environment? What systemic interventions might be required to design a neighborhood that minimizes geographical and spatial bases of health inequities caused by the built environment?

Textbox 1.3 Healthy Neighborhoods

WPHC Context

Where we live is important to our health. Our neighborhoods are defined not only by the houses we live in and their physical features such as the presence of walkways and green spaces but also by the sense of community they cultivate. Safe and aesthetically pleasing neighborhoods are characterized by plenty of green spaces, access to clean drinking water, good schools, healthy food sources, low air pollution, and high social connectedness. Healthy neighborhoods have the potential to support positive health outcomes by lowering stress and improving mental and physical health by providing greater

opportunities for physical exercise and healthy eating, among other mechanisms. Structural policies such as those promoting mixed-income neighborhoods can reduce residential segregation by social class and promote greater health equity by reducing differential access to preferential resources and services by disadvantaged populations (Roux, 2016).

SJA Prompt

A neighborhood is not a single, unitary entity. It is composed of several interrelated components, some of which are described in the WPHC context. Imagine an ideal neighborhood that supports the WPHC approach for all individuals in the community. As you brainstorm what a picture of a healthy neighborhood should look like, consider the effect of interrelatedness of neighborhood factors on the health of its residents and respond to the prompts that follow:

1. What would a neighborhood that provides a healthy environment for its residents look like?
2. What are some elements that a healthy neighborhood *must* have?
3. What are some elements that the neighborhood *could* have should resources permit?
4. How will the neighborhood meet the whole person health needs of people of all ages?

Resource

Roux, A. V. D. (2016). Neighborhoods and health: What do we know? What should we know? *American Journal of Public Health*, *106*(3), 430–431. https://doi.org/10.2105/AJPH.2016.303064

The SDoHs in the WPHC Approach

The WPHC approach considers the five key SDoHs and the need to collect, acquire, validate, analyze, and integrate the data about the many areas that comprise SDoHs. For instance, identifying an individual's housing status as part of the clinical record is now considered to be essential for understanding their health status. These new forms of data privilege nonmedical root causes of people's health issues, such as the stability of their housing situation, utilization of transitional or public housing, and/or the conditions characterizing an individual's living conditions in their homes (e.g., amount of unhealthy noise, dust, and environmental pollutants). Collecting medical data beyond individuals' biological markers can support how the healthcare experience is tailored to their daily lived conditions in whole person ways. For instance, understanding a person's housing status, education level, and languages spoken can be helpful in conceptualizing care that is effective in the patient's context. The SDoH perspective emphasizes an effort to understand why health inequities exist and aims to reduce them.

The Relational and Socially Constructed Nature of Health

One of the benefits of good health is that people are self-sufficient and do not have to depend on others to take care of them.

The Objectivist View

The objectivist view of the healthy individual draws upon theories of human physiological functioning and normative beliefs about human behavior, actions, and well-being, which is helpful in defining health and disease in the clinical domain. An objectivist approach considers health as being centered on the individual, removed from the factors that shape their environmental and sociocultural context. In the objectivist view, departures from the typical way in which people's bodies function help to determine malfunctions, and their corresponding assessments of health and well-being. Such an approach helps health communication and public health professionals design individual- and population-level treatments and interventions based on health risks and outcomes. For example, to confront smoking-related illnesses and sexually transmitted diseases, public health interventions and health communication campaigns target individual health beliefs and motivations to drive behavior change.

Limitations of the Objectivist View

Important understandings of health can be garnered through biomedical knowledge of human physiology. However, conceptualizing health as determined solely by objective biopsychosocial indicators has shortcomings. As explained next, by considering health from a relational and inclusive perspective and as an intersection of the many facets of an individual's physiological, biological, environmental, social, psychological, emotional, spiritual, and system-level factors, the constructivist approach to health is a central premise of the WPHC framework.

*Review **Textbox 1.4** for an understanding of the WPHC context of substance abuse disorders and attempt the SJA prompt.*

Textbox 1.4 Substance Abuse Disorders and Health Communication Contexts

WPHC Context

Substance abuse disorder (SUD) is a major health challenge in the United States. SUDs often co-occur with mental health disorders (e.g., depression, bipolar disorders, attention-deficit hyperactivity disorder, antisocial personality disorder, and psychotic illness). Health communication professionals play a vital role in shaping how people make sense of health issues, challenges, barriers, and behaviors.

SJA Prompt

Give an example of one communication initiative for each of the following health communication contexts:

- Campaigns
- Public relations
- Media
- Workplace

For example, an example of a campaign for the health communication context under the first column titled, "Campaigns," the *Truth Initiative* conducted a "Truth about Opioids" campaign in 2019. You would, thus, examine the campaign to respond to the following prompts.

1. Take one of the messages from that campaign and explain how it illustrates the whole person healthcare approach to SUD.
2. Does that message focus on a SJ concern, and, if so, how?
3. What actions does that message suggest?
4. Alternatively, is there some action you would recommend for addressing the SUD concern?

Resource

Truth Initiative. (2019, May 6). The truth about opioids campaign wins Emmy award. Retrieved April 26, 2021, from https://truthinitiative.org/press/press-release/truth-about-opioids-campaign-wins-emmy-award

The Constructivist Approach

The constructivist approach starts with the premise that health and disease reflect human biases. For instance, an objectivist approach will consider the healthy body norm as one that seeks to achieve a body weight in accordance with certain biomedical criteria and markers. In this instance, those over the desirable expectation of healthy body weight will appear as out of normative range. Thus, an objectivist approach will design health interventions to detect, intervene, and treat a condition and will drive behavior based on the motivation of weight loss through the association of body fat with health risks. For the objectivist, the research on blood pressure or life expectancy shapes the stigma associated with body weight, fat, and obesity. It assumes that being obese is not normal and places the onus for losing weight through interventions on the individual. A weight-inclusive constructivist approach, on the other hand, would claim that providing people with nonstigmatizing healthcare increases their ability to maintain a healthy body and achieve a state of well-being in relationship with their weight. A constructivist approach to healthy weight management will emphasize achieving the optimum weight for an individual based on health behaviors and nutrition approaches that fit into their lifestyle and values.

WPHC and a Social Constructionist Approach to Health

Social constructionism is a theoretical orientation that scholars employ to understand how people make sense of a phenomenon, such as health, illness, and disease.

UNDERSTANDING SOCIAL CONSTRUCTIONISM

Social constructionism argues that people make meaning of health through creating a shared understanding of how health conditions are experienced at an individual level, how meaning making occurs both individually and collectively, and how diseases are evaluated and treated.

Social constructionism will emphasize shared meaning making of health and disease as a sociocultural phenomenon rooted in understandings of illness, disease, medical knowledge, and treatment.

STRENGTHS OF A SOCIAL CONSTRUCTIONIST APPROACH

The social constructionist approach to health (social construction of health [SCoH]) is a useful lens for illuminating how people make meaning through interaction and dialogue and how these meanings shape our understanding of health and disease conditions. Illness and disease can carry a range of subjective meanings for different individuals, cultures, socioeconomic contexts, and time, and is not universal in their evaluation, assessment, or treatment approaches. The SCoH is central to the WPHC framework because it considers the whole person as shaped by the socio-historical, cultural, and individual influences on health-related meaning making, evaluation, assessment, treatment, and outcomes.

Health communication research employing SCoH reinforces an inclusive, integrative, and shared understanding of health in multiple domains. This research with populations who are disadvantaged shows how the SCoH accounts for the multiple intersecting factors that shape an individual's health and well-being status and outcomes.

Applications of SCoH in WPHC Contexts

Many communication scholars have conducted research using the SCoH perspective by people experiencing stigmatizing or under-researched health issues and negative media constructions. Rafferty and Sullivan (2017), for instance, studied how parents of children diagnosed with complex chronic conditions advocate for their children. They interviewed 35 parents of children diagnosed with chronic conditions. Their study found that parental advocacy was socially constructed through communicative behaviors in relationships with medical professionals, family members, and school educators. As another example, Gill and Babrow (2007) used problematic integration theory to examine challenges that women face in coping with their uncertainty about and the ambivalence they felt about having breast cancer. In line with the SCoH emphasis on cultural understandings of health, the findings showed that the coping approaches constructed through an interpretive analysis of all breast cancer articles appearing in top-circulating US women's magazines between 1997 and 2002 were somewhat imperfect. Coping was illustrated through simplification, information-seeking/provision, affect management, trusting intuition, sustaining hope, and metaphoric reframing.

Frohlich (2016) studied how people with inflammatory bowel disease (IBD) use social media networks to make sense of living with IBD and their struggles with coping with the stigmatizing views that people have of those with IBD as being unattractive. Her study takes a SCoH approach by eschewing objective and standardized definitions of IBD and attractiveness. The findings showed that those she interviewed who had IBD used social media technologies to redefine the subjective meanings of living with IBD by using different terms when speaking with others. Interviewees' redefinitions negotiated stigmatization that stemmed from surgery and its scarring effects on their bodies and adverse effects on their weight. The findings showed how the self-identity of those with a stigmatizing disease is (re)created by members of social media IBD groups about people's physical attractiveness, as when people posted photos of themselves that were "liked" by members of the community, it reconstructed the meaning of "physical beauty."

Focusing on how meanings are subjective and continually in the process of negotiation in SCoH, Omillion-Hodges et al. (2019) researched the meanings young adults ascribe to the word "death." They analyzed young adults' word choices used to describe death and how they

constructed meaning from these descriptions. Their study sought to gain insight into the communicative aspects associated with death and dying by understanding how the youths co-constructed the meaning of death in conversations. The researchers employed the communication management of meaning theory (CMM; see, e.g., Pearce & Cronen, 1980), which posits that meaning is constructed through six levels that build upon and are embedded in each other: (a) the content (e.g., verbal and nonverbal cues); (b) the performance of cues (e.g., speech acts); (c) contracts, or rules that guide interactions; (d) episodes, sequences of speech acts; (e) identity, or life scripts, which reflects individuals' sense of self as created through lived experience; and (f) cultural archetype. Their study showed that when youth talked about death, sociocultural beliefs related to values such as religion, spirituality, and expression of emotion, should be taken into no account. In this manner, in line with SCoH, meaning is not fixed but varies with context, content, and channel, among other factors.

Matsaganis and Golden (2015) examined reproductive healthcare disparities among African American women in a small, disadvantaged urban community located in the northeastern United States. Their study was guided by communication infrastructure theory (CIT), which looks at the multilevel storytelling network (STN) of micro-, meso-, and macrolevel actors that is set in its communication action context (CAC). Community residents are microlevel actors, whereas community-based organizations (community-oriented media) are mesolevel actors, with large institutions and media organizations being macrolevel actors. According to CIT, communication among STN agents is enabled and constrained by the CAC in interaction with the environment, such as organizational resources, transportation, and health-related resources.

Matsaganis and Golden (2015) studied how the women's urban environment and their social construction of that environment interacted to produce a "field of action." The researchers found that women with lower income and racial and ethnic minorities bore a disproportionate burden of negative reproductive health outcomes, ranging from disparities in maternal and newborn health outcomes and sexually transmitted infections (STIs) to reproductive tract infections and lack of access to and utilization of reproductive health services. Their study showed how the availability of healthcare resources, transportation services, communication resources, and personal privacy illustrate the dependencies among the STN and CAC factors, and the specific field of health action for the African American women in the community. They recommended that for healthcare interventions to be successful, they need to address the factors in an interdependent manner. For instance, they pointed out that an intervention, such as a taxi voucher program, must address people's transportation challenges alongside the barriers due to privacy concerns for the intervention to be completely successful. This study highlights how the interplay of individual and collective factors, a tenet of SCoH, shapes the understanding of effective interventions in achieving healthcare goals.

Reflexivity and Interdependence in Healthcare Approaches

Reflexivity in WPHC

Reflexivity references the aware, critical, and informed process of drawing on information or complex attributes of a phenomenon to make sense of and/or decisions with respect to that phenomenon. Reflexivity involves people thoughtfully and critically examining their beliefs, values, judgments, actions, and practices that they typically take for granted. Reflexivity is a central tenet of the WPHC framework because it encourages a critical and nuanced examination of health that is contextual, open to multiple interpretations, and emphasizes meaning

making processes as key elements of health. This section describes how reflexivity can be understood at an individual level, at a contextual level, and in the research process.

Reflexivity at an Individual Level

Communication scholars have studied reflexivity regarding how people make sense of health information. For instance, Mendes et al. (2017) studied "reflexive actors" who strive to make well-informed decisions about their health by actively seeking information and rationally considering its pros and cons. Specifically, they studied young adults' health information-seeking practices. The findings revealed that healthy young adults saw health professionals as reliable sources of health information advice, whereas they perceived online health information as unreliable. Mendes et al. defined reflexivity as an assimilation of complex and multilayered information through a thoughtful evaluation of its credibility, reliability, and trust to engage in informed decision-making.

Review ***Textbox 1.5****. Respond to the SJA discussion prompt that follows.*

Textbox 1.5 Reflexivity in SDoH-related Disparities in Cardiovascular Diseases: Media Messages

WPHC Context

Cardiovascular diseases (CVDs) are the leading cause of morbidity and mortality globally. People of color bear a disproportionate burden of CVD-related morbidity and mortality and poor disease outcomes. The evidence linking race and racism with negative CVD outcomes is increasingly becoming clear (Javed et al., 2022). Not surprisingly, this evidence indicates how the five key SDoHs (healthcare access and quality, education access and quality, social and community context, economic stability, and the neighborhood and built environment) shape barriers to CVD health and increase health disparities in this domain.

For instance, racial differences in socioeconomic determinants (e.g., in wealth and income) are associated with poor CVD health and quality of life. Black and Hispanic employees are 48% to 52% more likely to experience insecurity and be exposed to increased psychosocial occupational stressors stemming from low job control, long commutes, and high work-related demands (Schultz et al., 2018). Psychosocial occupational stressors are, in turn, strong predictors of CVD risk factors, including diabetes and hypertension. Increasing awareness of CVD risk factors is one way of addressing health-related disparities in the CVD domain. Media messages can play a powerful role in supporting the goals of WPHC in this regard.

SJA Prompt

Conduct an online search for recent promotional messages about CVD health (e.g., advertisements, campaigns, product marketing, brands, and/or organizational messages).

1. How inclusive are they of people of various races, ethnicities, ages, gender identities, and sexual orientations?

2. Which populations do they predominantly seem to address, and which are left out?
3. Take one of those messages and modify it to include one of the populations that is underrepresented.
4. How will you ensure you are being reflexive about your biases in designing the message?

Resources

Javed, J., Maqsood, M. H., Yahya, T., Amin, Z., Valero-Elizondo, J., Andrieni, J. … Nasir, K. (2022). Race, racism, and cardiovascular health: Applying a social determinants of health framework to racial/ethnic disparities in cardiovascular disease. *Circulation*, *15*(1). https://doi.org/10.1161/CIRCOUTCOMES.121.007917

Schultz, W. M., Kelli, H. M., Lisko, J. C., Varghese, T., Shen, J. … Sperling, L. S. (2018). Socioeconomic status and cardiovascular outcomes: challenges and interventions. *Circulation*, *137*(20), 2166–2178. https://doi.org/10.1161/CIRCULATIONAHA.117.029652

Reflexivity in the Contextual Level

REFLEXIVITY IN THE CONTEXT OF MEDIA REPRESENTATIONS OF HEALTH

Health communication researchers also have examined reflexivity about how media representations of health and people experiencing health issues represent health topics. For instance, in examining the swine flu in Australia, Holland and Blood (2013) focused on reflexivity as a means of critically engaging with media, evaluating the government's response, and enacting vigilance and behavior change by those who medical authorities deemed to be "at risk." Holland and Blood, thus, interrogated how people construct categories of who is deemed to be at risk and how those categories are informed by people's own value systems and taken-for-granted norms that subsume hierarchical relationships.

Reflexivity in Health Communication Research

RESEARCHER REFLEXIVITY

Communication scholars also have studied how researchers, themselves, engage in reflexivity. For instance, Russell (2019) examined how health communication researchers engage reflexivity in their embodied interactions with research participants to negotiate complex issues involving trust, vulnerability, and risk. Dutta (e.g., 2010, 2018) has centered reflexivity in their employment of the culture-centered approach (CCA) when examining health disparities for subaltern voices (see **Chapter 11, Global Health**, for more on the CCA). Reflexivity in the research process encourages researchers to interrogate how their identity and positionality shape the research process, interactions, and findings.

REFLEXIVITY IN THE RESEARCH PROCESS

Reflexivity also means that researchers consider their own thought process and its construction as it bears upon the focus of their research. For instance, Dutta and de Souza (2008) examined the sociopolitical context in which health scholars design health communication campaigns. They attended to tensions that health communication campaign designers experience between

the past and the present, the global and the local, and the modern and postmodern. Employing a critical cultural approach that examines the assumptions behind beliefs and norms, the researchers highlighted how campaign designers think through and become aware of the role of media, culture, health responsibility, structural conditions, and politics of knowledge. They took structure-level factors into account to understand how individuals who are socially disadvantaged are constructed as vulnerable vs. empowered and as having agency or as lacking agency. Their research reinforces how reflexivity has powerful implications for the agency of those whose voices are being represented by others. By encouraging individual ownership and critical examination of the beliefs and knowledge domains that contribute to the SCoH norms and conditions, reflexivity is central to fulfilling the goals of the WPHC approach.

Interdependence in WPHC

Interdependence directs people's awareness of their connections with others, social contexts, organizations, and with the environment. Interdependence considers mutual dependence, shared power, and cooperation in relationships. One theory that has been used often to understand interdependence in health contexts is the actor-partner interdependence model (APIM; Kenny et al., 2006). This theory considers the intrapersonal and interpersonal contexts of health behavior. Intrapersonal contexts refer to those facets of relationships that occur within a person, whereas interpersonal interactions refer to those that occur between people. In an interpersonal context, Matsuda (2017) used that model to examine how couples influenced one another regarding the connection between sexual communication and relationship power, general communication, and views on family planning. Magsamen-Conrad et al. (2019) applied the APIM to understand the response patterns of support, reciprocity, emotional reaction, and avoidance for romantic couples managing cancer. Interdependence helps to understand contexts of health disruption, such as those caused by cancer (Magsamen-Conrad et al., 2019). Communication of concerns and disclosure of fear and thoughts helps to manage illness, which, in turn, decreases the amount of distress and burden that the partner experiences (Stanton et al., 2002; Venetis et al., 2014). Interdependence has also been examined in spousal communication and sense-making after a miscarriage about its impact on spouses' well-being, perspective-taking, and relational satisfaction (Horstman & Holman, 2018).

Reflexivity and interdependence thus are important to WPHC, as they address key aspects of relational, emotional, and social health and well-being. As the next section shows, they also are key to health equity.

***Textbox 1.6** provides a select list of WPHC concepts with their definitions for this chapter. Attempt the SJA discussion prompt that follows.*

Textbox 1.6 Selected WPHC Concepts with Definitions

- **Health**: a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.
- **Well-being**: includes the presence of positive emotions and moods (e.g., contentment and happiness), absence of negative emotions (e.g., depression and anxiety), satisfaction with life, fulfillment, and positive function. Well-being can be described as people judging their life positively and feeling good (CDC, 2018, 2021).
- **Disease**: an illness or sickness characterized by specific signs or symptoms.

- **Social isolation**: the absence of social interactions, contacts, and relationships with family, friends, and neighbors, and with "society at large" (Berg & Cassells, 1992).
- **Biomedical knowledge**: pertains to the processes underlying the manifestations of a disease, and incorporates knowledge about domains that include biochemistry, microbiology, and physiology.
- **SDoH**: conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of-life risks and outcomes.
- **Value-based model of care**: View people as individuals whose health status should be interpreted as a confluence of socioeconomic circumstances that may make them vulnerable to health risks.
- **Complementary, alternative, and IM**: If a practice that is not mainstream is used **together with** conventional medicine, it is "complementary." If a nonmainstream practice is used **in place of** conventional medicine, it is "alternative." Integrative healthcare brings conventional and complementary approaches together in a coordinated way emphasizing a holistic, person-focused approach to healthcare and wellness—often including mental, emotional, functional, spiritual, social, and community aspects—and treating the whole person rather than, for example, one organ system. Integrative healthcare aims for well-coordinated care between various providers and institutions (NCCIH, 2021).
- **IM**: practice of medicine that reaffirms the importance of the relationship between healthcare providers and patients, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches, healthcare professionals, and disciplines to achieve optimal health and healing (American Board of Physician Specialties, 2021)
- **Transactional communication**: communication that is characterized by shared power, mutual influence, attentiveness to both verbal and nonverbal cues, and the value of feedback and diversity (du Pré & Foster, 2015).
- **Objectivist approach**: defines social problems by concrete, scientifically measurable damage conditions cause or objective dangers they pose to human life.
- **Constructivist approach**: defines social problems by the public concern that conditions generate.
- **Social constructionism**: theory of knowledge that holds that characteristics typically thought to be immutable and solely biological (e.g., gender, race, class, ability, and sexuality) are products of human definition and interpretation, shaped by cultural and historical contexts. Social constructionism highlights the ways in which cultural categories(e.g., "men," "women," "Black," and "White") are concepts that are created, changed, and reproduced through historical processes within institutions and culture.
- **Illness**: an anomaly that can manifest to create a condition of being unhealthy, sick, or diseased.
- **Communicative management of meaning**: theorizes communication as a process that allows people to create and manage social reality by describing how communicators engage in meaning making, which is understood as a hierarchical process, about their lived conditions.
- **CIT**: posits that storytelling is central to building and maintaining a community, as well as to effecting social change at the community level (Ball-Rokeach et al., 2001).

- **Reflexivity**: people being aware of their actions and the belief and value systems that guide them in critical and interpretive ways.
- **Interdependence**: processes, actions, or activities that require one individual to work with another.
- **Openness**: a basic personality trait denoting receptivity to new ideas and experiences. It is one of five core personality dimensions that drive behavior in the Five-Factor Model of Personality. People with high, as compared to low, levels of openness are more likely to seek out a variety of experiences, be comfortable with that which is unfamiliar, exhibit high levels of curiosity, and pay attention to their feelings.
- **Vulnerable populations**: Those at greater risk for poor health status and health access who are considered vulnerable, including racial and ethnic minorities; those who are economically disadvantaged; and those with chronic health conditions experience greater risk factors, worse access to care, and increased morbidity and mortality compared to the general population.
- **Agency**: capacity of individuals to act independently and make choices.
- **APIM**: a model of dyadic relationships that integrates a conceptual view of and statistical techniques for measuring interdependence.
- **Inclusive healthcare**: the ethical premise of the health-for-all ethos that recognizes and seeks to eliminate all barriers to people's participation in receiving health.
- **Right to health**: The belief that people have an innate entitlement to good health, with health understood as an inclusive right to the factors needed to help lead a healthy life (e.g., safe drinking water, safe food, adequate nutrition and housing, healthy working and environmental conditions; health-related education and information; and gender equality); freedoms (free from nonconsensual medical treatment, inhuman or degrading treatment, or punishment; equality of opportunity to enjoy the highest attainable level of health; right to prevention, treatment, and control of disease; and access to essential medicines, among others); health services, goods, and facilities provided to all without any discrimination; all services must be available, accessible, acceptable, and of good quality.

SJA Discussion Prompt

- In what way does this list of concepts and their definitions highlight the concerns of WPHC?
- What SJA themes stand out as most important to you in considering the goals of WPHC?

Resources

American Board of Physician Specialties. (2021). *Integrative medicine defined*. Retrieved from https://www.abpsus.org/integrative-medicine-defined/

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