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The Critical Cultural Turn in *Health Communication*: Reflexivity, Solidarity, and Praxis

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One of the earliest critical essays to appear in the pages of *Health Communication* was an article written by the scholar Deborah Lupton in 1994, titled “Toward the Development of a Critical Health Communication Praxis.” In her thought-provoking essay, Lupton invited readers to engage with the taken-for-granted assumptions that circulate in the dominant ideology of health communication, drawing attention to the interplay of power and control in the formulation of health problems and in the development of solutions. Critical scholarship in health communication interrogates the structures within which meanings of health are constituted, raising questions such as: How are the agendas of the status quo played out through the framing of specific problems in health communication research (Dutta, 2006; Dutta-Bergman, 2005; Lupton, 1994; Peterson, 2010)? What are the dominant ideologies that circulate in the privileging of certain sets of scientific claims in health communication research and practice (Dutta-Bergman, 2005; Thompson, 2010)? What are the values embedded in the claims to scientific legitimacy made by health communication research, and how are these values situated amid the political and economic agendas of dominant power structures (Dutta-Bergman, 2005; Lupton, 1994)? What then are the possibilities of resistance in the backdrop of these structures (Basu & Dutta, 2009; Donelle & Hoffman-Goetz, 2008; Dutta & Basu, 2008; Dutta-Bergman, 2004a, 2004b; Zoller, 2005)?

By noting the political, economic, and cultural spaces of knowledge production that participate in the framing of risks and the appropriate solutions corresponding to these risks, critical theory, on one hand, deconstructs the dominant frameworks of risk framing in health communication, and on the other hand, co-creates spaces for alternative framings of risk, alternative rationalities, and alternative solutions that challenge the dominant structures. From early on, then, the tone of critical health communication scholarship was established in terms of an agenda of interrupting the theory and practice of health communication in the mainstream, bringing to the forefront questions of social justice, equity, participation, and structural transformation. The interrogation of dominant structures is accompanied by critical projects that foreground local agency in the articulation of health meanings, co-construction of health problems, and participation in communicative processes of meaning making as entry points to working with and against the dominant structures of health care organizing (Dutta, 2008).

By asking questions about the nature of health communication theorizing and application development in the spaces of the journal, critical theory disrupts the universalist assumptions of altruism that are built into the rhetoric of much health communication work and brings the health communication theorist/practitioner face-to-face with the assumptions that serve as the foundations for carrying out health communication interventions locally, nationally, and globally (Dutta, 2006). For example, what is the value of population control programming targeted at the global South? What are the values embedded in population control interventions? Whose agendas do these interventions serve? What are the political, economic, and geostrategic agendas served by United States-run population control programs, historically carried out under the legitimating labels of “universal” and “scientific” truth claims?

Critical interrogations turn the lens back on the knowledge-producing enterprise that legitimizes the power structure and perpetuates inequalities of health. The questioning of the assumptions of science and universal value offers the framework for problematizing current forms of theory and practice, as well as for entering into the politics...
assumptions of universality

Much of health communication theorizing operates on the basis of West-centric universals that serve as the foundations of the interventions being proposed by health communicators (Dutta-Bergman, 2005; Lupton, 1994). What lies at the heart of health programs and interventions is the appeal to universalist science, simultaneously erasing the socially constructed, locally specific, and contested nature of science, and minimizing (in many instances, discarding) the spaces for critical interrogations through the so-called appeals to “progress” and “enlightenment.” The value of the proposed intervention is taken for granted, and interventions are carried out on target communities on the basis of “scientific claims.” Erased from the discursive spaces of health communication theorizing and intervention development are questions about the cultural and structurally situated values embodied in the “scientific claims” underlying the interventions. On one hand, the appeal to science lies at the foundation of the dominant articulations of health communication scholarship; on the other hand, there is no meaningful engagement with the scientific bases of the interventions being proposed (see, for instance, the critical questions about the values embedded in the “science” of organ donation raised by McGregor, Verheijde, & Rady, 2008). Critical health communication theory engages with the complexities that are constituted in this paradox of health communication theory and practice in the mainstream. As demonstrated by critical theorists in this journal, these assumptions of universality are themselves culturally loaded, value-based assumptions, situated within the West-centric foundations of health communication theorizing with neocolonial underpinnings (Dutta, 2006; Dutta & DeSouza, 2008).

Critical health communication theorists interrogate the values intertwined in the knowledge claims made by biomedicine, as well as the values underlying the social scientific theories that are the primary grounds of claims making for health communication scholars (Dutta, 2008; Dutta-Bergman, 2005). Critical questions noted in the domain of biomedicine explore the communicative processes constituted in the contested spaces of biomedicine, and situate these processes alongside the communicative processes constituted in other ways of healing and curing. These comparisons and interrogations draw attention to the cultural realms of values that are deeply intertwined with the ontologies and epistemologies connected with the ways in which health care providers, individuals, families, and communities identify problems and then work toward corresponding solutions. For example, Geist-Martin and Bell (2009) narrate a holistic approach to healing that highlights the authenticating role of communication between the provider and the patient, foregrounding the practices of listening, incorporating the words of the patient, empathizing with the patient, offering legitimacy to the patient’s authority, and mutually co-constructing knowledge. Following the lead of the Geist-Martin and Bell (2009) piece, future scholarship in health communication needs to explore the communicative practices of meaning making and interpretation through which widely ranging healing and curing processes are constituted across the globe amid contradictory, fragmented, and dynamic frames.

Moreover, the value-based interrogations of the social science underlying health communication scholarship draw attention to the culturally situated assumptions about human values, human identity, and human behavior underlying social scientific theorizing (Dutta, 2006; Dutta & DeSouza, 2008; Dutta-Bergman, 2005). Therefore, theories such as the theory of reasoned action, the health belief model, and the extended parallel process model have been critiqued for their assumptions of individualism, rational choice, and cognitive decision making. The hegemony of the social sciences is situated amid multiple fragmented, contradictory, and counter-hegemonic sciences that are rooted in ways of knowing located at the margins of dominant health communication theorizing, bringing forth the contradictions and tensions that exist in the discursive negotiations of health communication policies and programs globally.

Similarly, critical health communication scholars interrogate the assumptions of democracy and participation that have started emerging in contemporary health communication interventions (Dutta, 2006; Peterson, 2010). These critiques demonstrate the ways in which participation is co-opted to serve the implicit and explicit agendas of funding agencies, and participatory capacities of local communities are framed within the agendas of the status quo to create markets for transnational corporations (TNCs). They
also draw attention to the ways in which such participatory projects are often aligned with the neoliberal framing of participation as a tool for increasing the penetration of TNCs, locating responsibility in the hands of individual community members and emphasizing the participation of community members as consumers in the marketplace (Prasad, 2009).

For example, critical interrogations of the participatory communicative processes embodied in community-based participatory research (CBPR) point toward the co-optive function of participatory processes in serving the agendas of status quo research and in fostering “clientelism” in local communities (Peterson, 2010). Even as critical scholars are drawn to the emancipatory politics of participatory processes, these essays suggest that they ought to be continually reflexive about the meaning of participation, the agendas of participation, and the truly transformative capacity of participatory processes.

Critical interrogations of these assumptions accomplish two things. First, they rupture the dominant assumptions of a-cultural social sciences, demonstrating that the very constructs in the social sciences are culturally situated and therefore need to be treated as such. Second, they open up spaces for alternate theorizing from elsewhere that offers meaningful pathways for developing health communicative solutions that are aligned with the cosmologies and meaning frameworks of local communities across the globe. Spaces are opened up for local sciences, indigenous sciences, feminist sciences, etc. that offer alternative entry points into conceptualizing health, developing health solutions, and implementing these solutions (Shiva, 1988). These theories from elsewhere de-center the spaces of health communication theorizing, rendering them impure and forever bringing to question their monolithic superiority based on West-centric assumptions (Dutta, 2008; Dutta & Basu, 2008; Geist-Martin & Bell, 2009). Such de-centering lies at the heart of the decolonizing of the field (Dutta-Bergman, 2004a, 2004b, 2005).

**ASSUMPTIONS OF EFFECTIVENESS**

Much health communication scholarship operates on the basis of the assumption of effectiveness of the health interventions being proposed (Dutta-Bergman, 2005). This emphasis on the effectiveness continues to reiterate in the funded projects and the applied programs being developed by health communication scholars and practitioners. Critical theorists raise questions about the measures of effectiveness that are put into place, and the ways in which these measures are able to mitigate the concerns that members of local communities face in their daily lives. For instance, a critical interrogation of the question of effectiveness in the domain of the “Five a Day” campaign for cancer prevention among underserved communities would interrogate the very effectiveness of the promotion of fruits and vegetables in highly resource-deprived communities, noted in the backdrop of the structural, social, and environmental risks that put underserved communities at risks of cancer. The individual-level emphasis of interventions is questioned, attending to the structural patterns within which local experiences of health are situated and exposures to risks are constituted. The emphasis on measuring effectiveness at an individual level ignores the structural constraints and cultural contexts surrounding health behaviors and health risks (Basu & Dutta, 2007; Dutta-Bergman, 2005; Pasick, Burke, & Joseph, 2009).

Critical interrogations also attend to the effect sizes of interventions, and ask: What constitutes an acceptable effect size in the backdrop of the money being spent on an intervention? At what level is the effect being measured? For example, in health communication programs that position themselves as addressing health care disparities, which of the disparities are these programs actually impacting? What are the effects of such programs on addressing health outcomes, measures of mortality and morbidity? What are the effects of such programs on addressing the material inaccess to basic health resources faced in highly resource-deprived communities? What are the effects of such programs in addressing the structural disparities that exist across races, rural/urban communities, and socioeconomic status? Questions ought to be asked about the material outcomes attached to health communication programs, particularly in the realm of the fundamental inequalities that exist in access to health resources, services, and opportunities (Basu & Dutta, 2007, 2009; Dutta, 2008; Dutta-Bergman, 2004a, 2004b, 2005).

Also worth asking are questions of community involvement and sustainability of health communication programs in communities (Dutta-Bergman, 2005; Pasick et al., 2009). In this context, critical theorists raise questions about the length through which program effects sustain themselves. To what extent do the solutions proposed in the health communication programs sustain themselves in the communities being targeted? What are the long-term effects of health communication programs? Asking these questions calls for important dialogues among social scientists, critical theorists, and policymakers. Furthermore, questions of equity and social justice raised by critical theorists point toward the need for revising the measures of effectiveness that are typically circulated in health communication interventions.

Most fundamentally, critical health communication scholars point out that the processes through which criteria are developed, interventions are measured, and claims are made are political and economic processes (De Souza, 2009; Peterson, 2010). Attending to the contested nature of knowledge claims creates openings for participating in the political processes of knowledge production through which policy articulations are made, engaging dialogically with funding agencies, and continually seeking out entry.
points for developing health communication solutions that are humane, just, and equitable. Furthermore, critical interrogations of effectiveness foreground the absence of local communities from the policy and intervention platforms that develop messages targeting them. Therefore, a resistive turn toward culture-centered health communication theory and research emphasizes a process-oriented shift toward listening to local communities and co-creating knowledge through participation of local communities (De Souza, 2009; Dutta, 2008; Dutta-Bergman, 2004a, 2004b; Pasick et al., 2009). Such a move toward local community participation in shaping health problems and health solutions is transformative in its emphasis on listening to local voices as entry points to transformations in policies, programs, and broader institutional structures. Effectiveness is redefined from an individual-level emphasis to an emphasis on measuring the changes in the inequitable structures achieved through the participation of local communities.

ASSUMPTIONS OF INNOVATIONS

Although the dominant paradigm of health communication takes for granted the effectiveness of the intervention being proposed (say, eating five servings of fruits and vegetables per day), critical theorists draw attention to the relevance of these very innovations for the local communities (Lupton, 1994). The mammogram, for instance, is not treated as a sacred miracle, but instead is situated amid local discussions of risks, social constructions of risks, and the political and economic agendas that constitute the ways in which these risks are negotiated in expert communities as well as in local communities that are the targets of innovations. In critical interrogations of innovations, innovations are studied amid the social, cultural, political, and economic processes that are situated around them. For example, in his critical interrogations of the clinical trials industry operating globally, Prasad (2009) draws attention to the principles of neoliberal1 governmentality that turn Third World subjects into human capital for global transnational corporations (TNCs), constituted at the intersections of political and economic agendas of TNCs, nation-states, and knowledge-producing bodies. Similarly, in a critique of the utilitarian values underlying organ donation and transplantation campaigns, McGregor, Verheijde, and Rady (2008) draw attention to the political and economic processes through which persuasive messages encouraging organ donation are crafted, framing certain aspects of the values of organ donation, and simultaneously undermining/erasing its negative consequences. In these instances, critical interrogations draw attention to the political and economic agendas underlying interventions that are situated amid the capitalist logics of biomedicine, serving the political and economic agendas of the status quo and the knowledge-producing institutions embedded within the status quo.

In the backdrop of these questions raised about the values of interventions to local communities, critical theorists note the systematic erasure of local communities as these communities have been turned into passive target audiences for interventions (Dutta, 2008; Dutta-Bergman, 2005). For example, critical interrogations of the research on “fatalism” and “external locus of control” point out that the erasure of agency from local communities fundamentally serves then to establish and carry out the political economy of the intervention industry. Once the target audience has been fixed as an amorphous category, interventions may then be carried out in order to “fix” the negative traits in the audience. The identification of cultural traits as barriers similarly offers the justification for health promotion interventions that are then directed at addressing these barriers.

A critical stance, therefore, foregrounds the community as an active meaning-making participant, engaged in the dynamic and continually negotiated processes of meaning making, working amid structures, and simultaneously seeking to disrupt these structures (De Souza, 2009; Ford, Crabtree, & Hubbell, 2009). What is the value of the innovation to the local community, as articulated by the voices of local community members? How are these locally situated understandings of the proposed innovation similar to and different from the interpretation of the innovation among the expert community of theorists, program planners, and practitioners? Who develops the problem configurations and under what frameworks? Who benefits from the proposed innovation? The taken-for-granted altruism of the health innovation is brought to question, situated amid the political economy of the systems of knowledge production that create, circulate, and evaluate health communication knowledge. The expertise base of the proposed innovation is examined, situated in the backdrop of the everyday risks that are faced by local communities and are considered important by them (Basu & Dutta, 2009; Dutta, 2008; Dutta & Basu, 2008). Furthermore, spaces are actively co-created for participation by local communities and for collaborations in health activism that challenges and seeks to transform unhealthy policies (Basu & Dutta, 2009; De Souza, 2009; Zoller, 2005).

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1The neoliberal logic is fundamentally an economic logic that operates on the basis of the idea that opening up markets to competitions among global corporations accompanied by minimum interventions of the state would ensure the most efficient and effective political economic system. Therefore, proponents of the neoliberal logic argue that the public sectors around the globe ought to be privatized so that these sectors could operate most efficiently and effectively. The advent of the neoliberal logic on the global stage has been marked by the power and control of global organizations such as the international financial institutions (IFI)—the World Bank and International Monetary Fund (IMF), as well as the Global Agreement on Trade and Tariffs (GATT), which later evolved into the World Trade Organization (WTO), created with the goals of minimizing the barriers to global trade, and maximizing trading opportunities for transnational corporations (TNCs) across national borders.
ASSUMPTIONS OF CRITERIA

The traditional criteria that are utilized to evaluate an intervention are brought into question by critical theory. How are evaluation criteria for projects situated amid the power and control of dominant structures? How do funding agencies, for example, determine the criteria that are going to be used for the evaluation of grants? From where do these criteria emerge? And how do these criteria connect with the lived experiences of local communities? If health care disparity is the point of interest of specific interventions, are these interventions going to be measured in terms of attitude change? Is it adequate for a health disparities project to measure in a community the behavioral intention to obtain cancer screening? And how do these measures match up with any measure of the material disparities within the population (Dutta, 2008)?

For example, critical theorists working with health inequalities discuss the ways in which the narrowly focused emphasis on a specific aspect of an individual’s attitude, belief, or behavior misses out on the broader issue of health inequalities within the population (Dutta, 2008; Zoller, 2005; Zoller & Dutta, 2008a, 2008b). A critical dialogue therefore continually creates openings for interrogating the criteria that would be utilized for the measurement of specific health communication programs, rather than simply taking for granted the effectiveness of the criteria. For example, when addressing inequalities is considered as a primary criterion, attention needs to be paid to the unhealthy effects of neoliberal policies across the globe, and the ways in which privatization of health resources, opening up of markets, and consolidation of power in the hands of TNCs have fostered unhealthy environments for the poorest of the poor (Coburn, 2000, 2004; Dutta, 2008; Zoller, 2005).

Furthermore, critical health communication scholars suggest the relevance of engaging with alternative criteria such as authenticity and meaningfulness. How meaningful, for instance, are the evaluation criteria to the local community (Dutta & Basu, 2008; Kline, 2007)? How do the criteria tap into the authenticity of the health communicator in engaging with the voices of the local communities? Especially as health communicators participate in large-scale projects that often remove them from the actual sites of data gathering, critical theorists interrogate the viability of sincere scholarship when the scholar herself/himself is far removed from the people who emerge as data sources in her/his study. What is the minimum level of acceptable contact that the health communication scholar needs to develop with the community? How much time should the scholar spend in the community? Authenticity and meaningfulness call for active participation by the health communication scholars in the complex and messy world of meaning-making, amid the politics of health and structural transformations in local communities. Critical interrogations privilege native and indigenous ethnographies as entry points for making knowledge claims, highlighting the capacity of local participants in co-creating knowledge that is more meaningful, compared to top-down knowledge about the community produced by outside experts (Dutta, 2008).

Meanings are continually contingent in such interactions, bringing forth complex stories and multiple counter-hegemonies that do not quickly lend themselves to narrow categories to be mapped out (Basu & Dutta, 2007; De Souza, 2009; Dutta & Basu, 2008). Our roles as health communication experts are challenged as we participate in the field to make sense of the complexities, paradoxes, and tensions constituted amid local communities that work in multiple ways to enact their agency (Eisenberg, Baglia, & Pynes, 2006). It is in these continuous interrogations of what it means to be authentic in our relationships with the communities that we work with that we, as health communicators, negotiate the ethics of the stories we have been entrusted to narrate (Eisenberg et al., 2006; Harter, 2009; Quinlan, 2010; Sharf & Vanderford, 2003). What kinds of stories are we going to narrate? And how do these narratives invite us to co-participate in an imagination and creation of a humane world (Harter, 2009; Sharf & Vanderford, 2003)?

THE PRAXIS OF CRITICAL HEALTH COMMUNICATION

In summary, critical health communication scholars participate in the praxis of health communication through their continuous reflexivity that turns a critical eye on the structures, processes, and practices of knowledge production. Reflexivity implies the turning of the lens inward. The interrogation of knowledge practices in health communication through engagement with the discursive closures and co-constructive possibilities creates a dynamic space that is fragmented, contested, and continually revised on the basis of journeys of solidarity with marginalized communities. The appearance of critical scholarship in the pages of Health Communication stands as an invitation for future scholarship that deconstructs the interplay of power and control, co-constructs possibilities for changes in health policies, and seeks out redistributive justice and structural transformation. Ultimately, as noted by Farmer (1999, 2003), the emancipatory politics of healing are embedded in the capacity of health scholarship to challenge and transform structural violence. It is my hope that we will see many more health communication scholars who take seriously the task of deconstruction, and who engage such deconstructions with the theory and practice of health communication. Also, I hope that the agenda for critical health communication scholarship of the next generation would continue to explore co-constructive processes through partnerships with local communities that seek to bring about transformations in local, national, and global structures by fundamentally attending to the agency of individuals and
collectives living at the margins to define their own problems and participate in processes of change to address these problems.

REFERENCES


