Rethinking Culture *in* Health Communication

Social Interactions as Intercultural Encounters

Elaine Hsieh
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WILEY Blackwell

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Dedication

Rudy and Tigger, thank you for your playful spirit and companionship.

Source: Elaine Hsieh

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1

Rethinking Culture in Health Communication

The chapter provides an overview of traditional and emerging fields of health communication, highlighting its interdisciplinary and applied nature as a field of research and practice. We will then explore how culture has been incorporated in health communication and examine the failure in organizing and conceptualizing the field in general through a cultural lens. We will present theoretical backgrounds and a conceptual framework that grounds the cultural perspectives discussed in this book. We will propose some learning objectives for our readers.

I. The Expanding and Interconnected Fields of Health Communication

This book is published at a historical moment that is seared into everyone's memory and is likely to transform our everyday life and redefine who we are. On December 31, 2019, the World Health Organization (2020b) received a report of a cluster of cases of pneumonia in Wuhan, Hubei Province in China. By July 4, 2020, the COVID-19 pandemic has reached over 11 million cases and over 530,000+ deaths worldwide, including 2.8+ million cases and nearly 130,000 deaths in the United States (Johns Hopkins Coronavirus Resource Center, 2020). At this writing, the numbers are accelerating in growth (see Figure 1.1). In 15 weeks, over 48 million Americans have filed for unemployment since mid-March when President Trump declared a national emergency concerning the COVID-19 outbreak (Menton, 2020; White House, 2020). Among those who lost jobs, poor Americans were hit the hardest: 39% of former workers living in a household earning $40,000 or less lost work; in contrast, among those making more than $100,000, 13% lost jobs (Smialek, 2020; see Figure 1.2). Worse yet, it is estimated that COVID-19 may leave 27 million Americans to lose their employer-sponsored health insurance coverage after being laid off (Garfield et al., 2020) – during a time when healthcare coverage is essential to protect individual health *and* family wealth.

On May 25, 2020, George Floyd, a 46-year-old African American, repeatedly said, "I cannot breathe," and eventually died in police custody after an officer kneeled on his neck for 8 minutes and 46 seconds during an arrest (see Figure 1.3). Despite the risk of exposure to COVID-19, numerous protests were held in small towns and big cities in the United States and internationally to demand justice for George Floyd, raise awareness of

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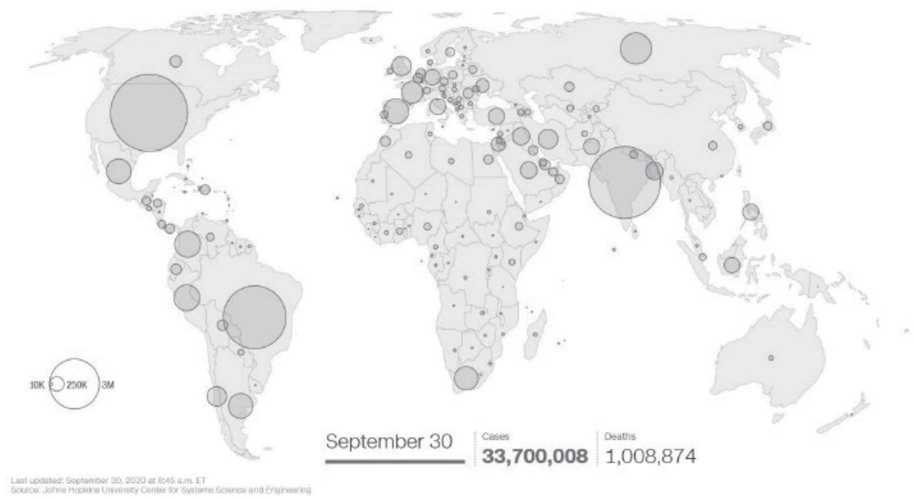

Figure 1.1 Global map of total cases of the COVID-19 pandemic (September 30, 2020). Adapted from the interactive map by CNN (Pettersson et al., 2020). *Source:* Adapted from Pettersson, et al. (2020, July 5).

Figure 1.2 Long lines for food bank. Drivers in hundreds of vehicles wait for central Texas food bank volunteers to deliver 28-pound boxes of staples during a food giveaway in Austin, Texas. Almost 1,500 families picked up boxes in response to extensive COVID-19 pandemic job losses and general economic fallout. *Source:* Bob Daemmrich / Alamy Stock Photo

unconscious bias, and seek solutions to structural racism. During the eight days of national civil rights protests, 62,000 National Guard soldiers and airmen were deployed to protests in 24 states plus the District of Columbia (Sternlicht, 2020). Over 4,400 people have been arrested as protests occur in all 50 states (Sternlicht, 2020). Over 40 cities have instituted curfews, including Minneapolis, New York, Louisville, Philadelphia, Chicago, and San Francisco (Sternlicht, 2020).

Figure 1.3 A mural dedicated to George Floyd. The mural also includes names of many other victims in honoring the Black Lives Matter movement in Minneapolis, MN, on May 29, 2020. *Souce:* Sipa USA/Alamy Stock Photo

We do not see the pandemic, the economic crash with millions losing health insurance, and the civil rights protests as three independent, random events that just happened to take place at the same time in history. Rather, these events are interconnected, highlighting the social injustice and structural barriers faced by the poor and the marginalized. Of the three, the pandemic and structural inequality along racial lines exist all over the world. However, the lack of universal health insurance in the United States is unique among wealthy industrial nations (Béland et al., 2016), which compounds the damages from the other two crises. Together, they tell a story of institutional failures to effectively protect, communicate, and listen to its most vulnerable citizens, responding to the social injustice and structural barriers that have limited their ability and potential to thrive over time, from one generation to the next.

Health and illness are pervasive in our everyday life. How we live our life, structure our social system, and respond to health disparities have consequences not only to our individual health, but also our family's financial well-being and our community's ability to thrive as a whole. How we conceptualize health and illness will define our abilities to find solutions and address injustice. To this end, we must see health and illness more than a biological phenomenon.

A. The Landscape of Health Communication

Caring for patients can be traced back thousands of years to ancient times in Greece and Roman; however, modern medicine only emerged in its current form in the 19th century (Bynum, 2008). The latest trends in medical science have become increasingly focused on advancing the institutional and scientific knowledge of the biological body (Bynum, 2008; Mukherjee, 2016). Medicine and healthcare providers also have begun to recognize that health and illness are situated in social, cultural, and economic

contexts (Rosen, 1958/2015). The 19th century sanitary movement (i.e., the introduction of piped water to people's homes and sewers rinsed by water) is considered the greatest medical advance since 1840 (Ferriman, 2007). Medical sociology first emerged in the 1950s to address how the politics and of health and illness can maintain and even reinforce systemic disparities and social injustice in the post-WWII period (Brown, 1991; Bury, 1986).

Compared to these fields, health communication, first formalized in the early 1970s, is a relatively young but rapidly growing discipline (Kreps, 2014). *Health Communication* and the *Journal of Health Communication*, two leading academic journals in the field, were established in 1989 and 1996 respectively. From its beginning, health communication has been influenced by a wide range of disciplinary approaches, including communication, psychology, medical sociology, and clinical medicine (Kreps et al., 1998). A review of published articles in *Health Communication*, the first academic journal focused solely on health communication scholarship, from 1989 to 2010, found that the field has been heavily influenced by western scholarship because the nationality of first authors was mostly United States (90.5%), followed by Canada (2%) and Australia (1.5%; Kim et al., 2010). In addition, over 50% of the total publications aimed at improving the penetration of health messages (i.e., persuasion) to targeted groups (Kim et al., 2010). Notably, Kim et al. (2010) concluded that individuals have been the focal level of analysis and there is "an absence of focus on structural factors or social policies that are more conducive to improving the health conditions of social members" (p. 500).

However, the landscape of health communication has expanded significantly since 2010 (Kreps, 2014). In particular, health communication scholars have collaborated with researchers from other disciplines, including medicine, public health, social work, critical studies, cultural studies, education, history, humanities, ethics, public policy, and law, to create new understandings and new approaches to the investigation of communication in health contexts. Here are some of the major themes and trends in health communication, along with some exemplars from this book.

1. Persuasion and Behavioral Change: Public Health Campaigns

As a major theme within health communication, **health promotion** centers on the persuasive use of communication messages and media to promote public health (Kim et al., 2010; Kreps et al., 1998). Scholars of mass communication, message designs, message effects, social influence, persuasion, and even political communication scholars have long investigated the *development*, *implementation*, and *evaluation* of persuasive messages in inducing behavioral changes in the public. As a result, this is a field that includes theory-oriented research (e.g., testing and evaluating message designs and effects) as well as practice-oriented fieldwork (e.g., executing actual campaigns through mass media).

Public health campaigns represent a valuable and rewarding testing ground to examine how persuasive messages can maximize public health benefits through (a) *promoting specific health behaviors*, including one-time health behaviors (e.g., vaccination) and long-term health maintenance (e.g., safe sex practices and regular physical exercise), and (b) *targeting specific populations*, including at-risk populations (e.g., individuals with mental illness, heart disease, or substance abuse problems) and the general public (e.g., five-a-day campaign for fruits and vegetables). This is an area that is heavily influenced by the sociopsychological traditions of health communication,

largely informing and informed by theories of health beliefs, risk perceptions, fear appeals, and compliance.

In Chapter 6, we will examine major theories in public health (e.g., Health Belief Model, Theory of Reasoned Action, and Theory of Planned Behavior). We will discuss how the underlying principles and presumptions in these theories reflect values grounded in the West. In Chapter 13, we will explore how tailored health communication and related theories can be informed by a cultural approach to community-based health interventions. In addition, we will examine how different cultural perspectives can bring new insights into future theories and practices of public health campaigns.

2. Interpersonal and Group Communication: Healthcare Delivery

As a field of inquiry in communication, **healthcare delivery** investigates how communication can influence the *access*, *process*, and *outcome* of care. Medical sociologists provided some of the earliest work on examining the communicative processes and power dynamics in provider-patient interactions in clinical settings (e.g., Kleinman, 1980; Parsons, 1951). By conceptualizing medicine as a cultural system, these scholars examined how communication can maintain and reinforce power hierarchy in and social control over patients' illness experiences, silencing their voices and suffering. In addition, because healthcare providers are knowledgeable professionals, their interactions with laypersons who are unfamiliar with the cultural perspectives of medicine are best understood as cross-cultural encounters (Ruben, 2016). In Chapters 3 and 4, we will compare and contrast the cultural perspectives of patients' lifeworlds and providers' culture of medicine.

Communication scholars in interpersonal communication further connected provider-patient communication to the quality of care by connecting the communicative content and processes to health outcomes, including patients' subjective experiences (e.g., satisfaction and understanding) and behavioral outcomes (e.g., treatment adherence) with clinical indicators (e.g., improved biological status; e.g., Cegala et al., 2008; Robinson & Heritage, 2016; Street, 2013). Alternatively, communication scholars also investigated how patients' characteristics (e.g., low health literacy and race) can shape their health behaviors and interactions with health professionals (e.g., Johnson et al., 2004; Miller, 2016). Expanding their analysis from clinical care, communication researchers have also explored how communication between members of social networks (e.g., family members, friends, and supportive others) can influence individuals' health behaviors and health decisions (e.g., Scott & Caughlin, 2015; Thompson & Parsloe, 2019). By conceptualizing health management as a communicative activity coordinated between multiple parties, group communication researchers also have examined how interprofessional health teams, patients, and supportive others coordinate with one another to achieve optimal care.

In Chapter 4, we examine how providers' medical training socializes them with the cultural perspective of medicine, which can create tensions with their own and patients' other cultural attitudes. In Chapter 5, we examine how healthcare providers' culture and patients' cultural perspectives can impact the quality of care. In Chapter 7, we will examine health literacy as a theoretical concept and a communicative skill in shaping individuals' health experiences. In addition, by situating health literacy in sociocultural contexts, we challenge readers to consider how health literacy may operate differently for members of the dominant versus non-dominant groups.

3. Sense-Making and Coping: Lived Experiences

Lived experiences highlight individuals' health and illness as socially situated and culturally contextualized experiences. By viewing communication as a resource and product of social constructions of meanings, both sociologists and communication researchers have relied on patients' illness narratives to gain insights into patients' lived experiences (Bury, 1982; Charmaz, 2002; Frank, 1998). These researchers recognize that the *meanings* of health and illness are coordinated between the patients as well as their supportive others and are not necessarily defined by biological symptoms. For example, a Hmong patient may believe that epileptic seizures are indicators of one's identity as a shaman, a divine gift from God, rather than misfires of abnormal electrical signals in one's brain (Fadiman, 1997). By situating individuals' health and illness in sociocultural and sociopolitical contexts, researchers have explored how patients may incorporate cultural-specific resources in their illness experiences and coping strategies.

In Chapter 2, we discuss how Native Americans' and Jehovah's Witnesses' strong identification with their cultural/religious identities are essential in shaping their health decisions. In Chapter 3, we discuss the importance of stories and storytelling in helping patients to make sense of their illness experiences *and* the larger community to uphold values and principles to which they aspire. In Chapters 9 and 13, we explore how religion can provide valuable frames in helping patients to make sense of their illness experiences and suffering. In Chapter 10, we examine how blood ties and filial piety, a Confucian cultural view that guides parent-child relationships, can empower cultural participants and motivate social support between family members in Chinese culture. In Chapter 12, we discuss how marginalized communities may adopt risky health behaviors to perform desirable identities and relationships and to engage in social resistance against dominant cultures.

4. Pan-Evolution of Medicine and Technology: Transformative Technologies

We use the term **transformative technologies** to highlight that technologies not only change the way we communicate but also create fundamental, structural changes in the surrounding environment. Advances in technologies are transforming the landscape and paradigms of medicine and health management. We use the term "pan-evolution" to highlight how the changes are not one-directional nor linear. **Pan-evolution** means that changes in one can lead to changes in all others that are connected in the system. In other words, emerging technologies create interactive, rippling effects on how people understand, communicate, and manage health and illness. In Chapter 11, we explore how advances in genetic medicine can change how an illness is conceptualized and legitimized. For example, a person who is physically healthy can become an eligible patient for a mastectomy, an aggressive surgical intervention, when they carry BRAC1 mutation, a genetic mutation that has been linked to an increased risk of cancers based on statistical models. The rippling effects of transformative technologies are not limited to advanced knowledge in medical science. For example, in Chapter 8, we examine how the early history of genetics facilitated social injustice and racial disparities as it promoted eugenics and led to the legalization of forced sterilization for marginalized and vulnerable populations.

Communication technology is vital to recent developments in risk communication. **Risk communication** refers to "the exchange of real-time information, advice and

opinions between experts and people facing threats to their health, economic or social well-being" (World Health Organization, 2020a, para. 1). The availability of big data technologies and the popularity of mobile technologies and social media have made risk communication essential in disseminating information as well as detecting and responding to misinformation in emergencies and disasters. In Chapter 11, we also examine how big data technologies, mobile technologies, and social media have made it possible to identify people who may be ill *before* they know that they are sick. More importantly, we will examine how such technologies can trigger fundamental shifts in cultural perspectives, treatment paradigms, and redefine public health.

5. Social Structure and Health Disparities: Health Policies

Although investigations of structural factors and social policies were lacking in the early development of health communication (Kim et al., 2010), communication researchers recently have connected beyond disciplines in social sciences to explore how communication can maintain, reinforce, or resist social structures that legitimize disparities for marginalized and vulnerable populations. Two approaches have led the development in this trend: (a) medical humanities, and (b) social activism. **Medical humanities** is an interdisciplinary approach to conceptualize medicine through some combination of its relevant disciplines – ethics and philosophy, religious studies, history, and literature (Bleakley, 2015; Brody, 2011). By situating health and healthcare practices in sociohistorical contexts, ethics, and aesthetics, researchers are exploring how public discourse and communication about health concepts and practices can reflect and invoke sociopolitical conflicts and tensions and also serve as a resource and product of social control and of social resistance (e.g., Jensen, 2010, 2016). In Chapter 12 and Chapter 14, we will examine how medical schools are transforming their curriculum and institutional practices to (a) enhance providers' cultural competence and (b) educate students about historical and social injustice faced by marginalized populations.

Alternatively, scholars of critical studies, cultural studies, and health policy studies have collaborated with grassroots, activist organizations to engage in structural, cultural-level changes in health disparities (e.g., Dutta & Zapata, 2019; Zoller, 2006). Recognizing that individual-level prejudice and institutional-level stigma are best analyzed and addressed through structural and policy considerations, researchers are describing and analyzing how historical injustice through laws and instructional policies can create disparities in a wide range of areas in life, including social, economic, and health disparities. In Chapter 2, we will examine how the conceptualization of Black as a racial category was grounded in historical discrimination, legitimized by laws and governmental policies, and continues to shape individuals' understandings of this racial category today. In Chapter 14, we will explore the complex and nuanced working of structural barriers and consider how theories of distributive justice can provide insights into how to best address health disparities in the larger society.

B. Conceptualizing Culture in Health

In recent years, scholars have become increasingly concerned about our failure to recognize the complexity and diversity in social science research (Jones, 2010; Rad et al., 2018). A significant majority of the publications about human behaviors and

psychology are based on **WEIRD** participants (i.e., relying on participants who are "overwhelming Western, Educated, and from Industrialized, Rich, and Democratic countries;" Brookshire, 2013, para. 2; see Figure 1.4). A study of publications during 2006–2010 in high impact journals in developmental psychology found that WEIRD participants account for 90.52% of the research subjects from whom claims were extrapolated and generalized (Nielsen et al., 2017). But we know that WEIRD participants differ from other populations in visual perception, spatial reasoning, reasoning styles, categorization and inferential induction, self-concepts and related motivations, as well as perceptions of fairness, cooperation, and moral reasoning (Henrich et al., 2010a, 2010b).

Communication scholars recently have utilized the platforms of the National Communication Association (NCA) and the International Communication Association (ICA), two of the largest professional organizations in the field of communication, to challenge the history, development, publication patterns of the discipline as well as the choice of NCA Distinguished Scholars and ICA Fellows (Chakravartty et al., 2018; Gardner, 2018; Mukherjee, 2020). Based on an analysis of publications and citations in communication journals between 1990–2015, Chakravartty et al. (2018) concluded that "non-White scholars continue to be underrepresented in publication rates, citation rates, and editorial positions in communication" (p. 254). #CommunicationSoWhite became the entry point of recognizing the struggles and silencing faced by some, and the point of reflection of one's privilege and responsibilities for many. Mukherjee (2020) argued, "Communication-So-White is a profoundly raced and gendered formation that polices our work methodologically, theoretically, and institutionally. ... Communication-So-White maintains the structural and ideological apparatuses of white privilege by rendering such privilege invisible in the ways we are expected to see and know" (p. 2). In short, "communication scholarship normalizes Whiteness" (Chakravartty et al., 2018, p. 262). When we fail to critically and reflexively recognize how the knowledge production perpetuates the views of a specific cultural perspective/group as the norm/standard, we inevitably maintain and reinforce a distorted reality.

Figure 1.4 WEIRD as cultural perspectives. In what ways do you think your WEIRD status makes you different from non-WEIRD others? *Source:* Rubberball/Weston Colton/Getty Images

Because social science is a field of research that emerged from the West, we are inevitably limited by western thinking, cultural perspectives, linguistic limitations, and even imaginations (see Figure 1.5). This is not a "fault" per se as we are all limited by our cultural imaginations. We can only recognize our own cultural perspectives and limitations when we encounter "differences." Raising concerns about how citational segregation (i.e., a preference for citing authors who are members of the same group) can reinforce established patterns of disparities and professional socialization within the discipline, Chakravartty et al. (2018) argued that it is not sufficient to add more scholars of color. After all, if *all* scholars continue to be trained in and are expected to be familiar with (and cite) the literature that holds predominately western and White worldviews, such an approach will only continue to reinforce disparities and exclude other non-dominant (cultural) perspectives. Chakravartty et al. (2018) concluded that "rethinking normative theories of communication" is necessary to address the predominately White perspectives in the field (p. 261).

Culture is an essential factor in shaping individuals' understanding and behaviors in healthcare settings. Traditionally, the fields of public health and health communication have treated culture as an important caveat, noting that many of the findings may not be valid or applicable to individuals and organizations from non-western cultures. How can culture be an important contextual factor yet functions as a "caveat," an outlier that creates noise to observed patterns? More importantly, such an approach to culture in health context (or communication in general) also fails to account for the roles, functions, and impacts of culture in the West. This is reflected in the lack of systematic discussion and conceptualization about how culture, as a contextual factor, (a) serves as a resource and a product of individuals' health behaviors, (b) shapes communities' responses in offering support for some yet silencing suffering for others, and (c) shapes institutional structures and policies that reinforce disparities or minimize injustice. In other words, culture in the WEIRD-based literature becomes invisible. If western, modern, and/or industrialized societies are under the influence of culture, how can we theorize culture to explain our understanding and behaviors of

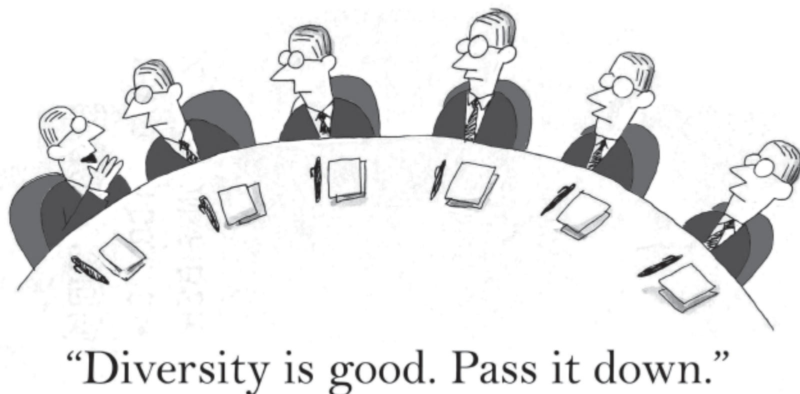

Figure 1.5 Diversity is good. Until and unless we begin to see outside of our cultural perspectives, we cannot truly understand ourselves or others. *Source:* YAY Media AS / Alamy Stock Photo

health and illness – not just as a caveat or a contextual factor for non-western people but for *all* people?

In this book, we will *situate culture front and center*, examining its complex definitions and dimensions and exploring the various pathways in which culture can shape patients' illness experiences and providers' behaviors. We will examine how culture may create challenges and dilemmas in cross-cultural healthcare in which various individuals and institutions may hold diverging, if not incompatible, views of ethics and reality. More importantly, we do not view culture as something that is limited to ethnic minorities or marginalized populations. Rather, we argue that all people are cultural beings: We embody our cultures. Culture is enacted, performed, and negotiated in our everyday social interactions.

This book will begin by building a solid and comprehensive foundation on the understandings of different forms, functions, and meanings of culture and integrating health related examples. In later chapters, we will systematically examine major themes in health communication. This book adopts an interdisciplinary approach to examine culture as a resource and product of healthcare settings. In this book, we focus on three general areas: (a) culture and health behaviors (Chapter 2–5), (b) health as socially coordinated activities (Chapter 6–11), and (c) health disparities and health policies (Chapter 12–14). We are heavily influenced by the fields of cultural phenomenology, philosophy, anthropology, psychology, sociology, sociolinguistics, communication, public health, and ethics, among others.

II. Foundational Framework: Dimensional Accrual and Dissociation

The foundational framework for this book includes the Theory of Dimensional Accrual and Dissociation (i.e., DAD; Kramer, 1997, 2013) and cultural fusion theory (i.e., CFT; Kramer, 2000, 2019). Both theories are based on prior research in the fields of comparative civilizations (Gebser, 1949–1953/1985, 1996), intercultural communication (Campbell, 1988/2011), and cultural structures (Mumford, 1934/2010). We have also extended DAD and CFT by proposing specific terms to highlight the unique aspects of the four primary cultural perspectives. We propose that cultures can be understood from three perspectives: Magic Consciousness (e.g., all lives are connected as one), Mythic Connection (e.g., stories and narratives that strengthen group norms and values), and Perspectival Thinking (e.g., science). These cultural perspectives also blend with one another, creating an Integral Fusion worldview (e.g., a scientist who is also highly religious). We then use these cultural perspectives to examine existing theories in health communication and health policies.

We chose the skeleton dressed in festive colors for the Day of the Dead as our book cover because it highlights the different perspectives of what we are trying to accomplish in this book. On *Día de los Muertos*, the Day of the Dead, people believe that the dead are just as "alive" and "real" as the living (i.e., Magic Consciousness). The day of the event is rich with stories that call for cultural beliefs and values for the living (i.e., Mythic Connection). Yet, in medicine, we often see skeletons as an impersonal object to be studied in human anatomy (i.e., Perspectival Thinking). The blending of all of our cultural frames into one is Integral Fusion (i.e., a dressed-up skeleton treated as a

living person on a cultural-specific holiday to remember one's ancestors and follow community values). We will detail these cultural perspectives and explore their applications in health contexts in Chapter 2–5.

Before taking an in-depth look at each cultural perspective, we need to understand what is borrowed from Mumford (1934/2010) and Gebser (1949–1953/1985, 1996) in order to understand the DAD and CFT theories. Both Mumford and Gebser are NeoKantians. This means that they adopted many of the insights found in the works of Immanuel Kant (1798/1992, 1781/1999, 1786/2011).

A. Kant: Lifeworld as a Product of Constitutive Activity

Though we may imagine a world without human awareness, the only access we have to the universe is through our minds: our living minds render a world of sense and meaning. Our Lifeworld is constructed through our language and culture. Because there are many different languages and cultures, there are many different Lifeworlds, yielding different worldviews. We embody our Lifeworld and cannot be separated from it. This is because our experiences, perceptions, and understanding of realities are products of our human consciousness, which is shaped by our language and culture. Our consciousness structures experiences and "realities" for us – and this includes what "I" and "We" are and mean. Entire cultures tend to have collectivistic or individualistic senses of self, motives, values, and beliefs.

Kant's (1798/1992, 1781/1999, 1786/2011) great discovery was that the mind structures our perception. Kant (1781/1999) was the first to describe how awareness or consciousness is a product of the human nervous system, which includes the brain and all channels that feed into it. Kant noted that consciousness is a synthetic product: Consciousness is a result of synthesis and integration of all our memories, emotional states, sensory stimuli, and so forth. What this means is that information flows into the brain from our various senses, including complex messages (e.g., our sense of balance) and non-sensory information (e.g., memory, moods, and reasoning). **Consciousness** refers to all these different sources of information that are then combined into a coherent and consistent flowing awareness in real-time (Kramer, 1992a). In other words, consciousness forms the basic architectural structure that governs how all these different sources are combined. This process is constitutive: Out of many channels of information, one unified stream of awareness is synthesized by an active mind to create a coherent meaning (i.e., sense-making). Kant called the architectonic construct of the *human manifold* "a projection of an a priori intuition, a manufactured totality, in unconscious thought, onto the phenomenal world" (p. 46).

According to Kant's initial conceptualization, the basic dimensions of the architecture are the categorical *a priori* of space and time. The categorical *a priori* (space and time) form the structural logic that gives patterns and sense to all the information flowing into the brain. This architecture was universal and natural, grounded in *all* human minds. It was not a consequence of culture. The old nature versus nurture argument was very common during the Enlightenment when Kant was writing. He tended to see his work as discovering a universal and natural process. In other words, Kant initially believed that *all* human beings experience space and time the same way and that such experiences form the structure for the synthesis of all other experiences.

Kant (1724–1804) was writing in the seventeen and eighteen hundreds in a city in Northern Europe along the Baltic Sea. Kant initially believed he had discovered the universal structure for all human consciousness. But he began to suspect that there may be more than one architecture. His work was widely celebrated as one of the greatest accomplishments of the Enlightenment. Nevertheless, by the end of his life, he began to question the scope of his theory of consciousness, suspecting whether it was, in fact, true for all humans or limited in application. Living in a port city, Kant had the opportunity to meet with many people who had traveled to distant lands. Europe was entering its greatest period of colonial expansion and global exploration. As he met with travelers, they described to him people and distant cultures that did not share the same sense of time and space as Northern Europeans.

As he began to recognize the possibility of cultural variations, Kant started to recognize that the human brain is both a biological organ of the body and a social organ: its structure, the neuronetwork was a product of communication and culture. The human brain and the consciousness it generates are products of both biological factors such as genetics as well as being a cultural product. Even before the child is born, cultural issues (e.g., availability and form of prenatal care) can affect the brain.

The human brain is not finished at birth. The way it is formed is a result of our personal experiences, which are based on social interactions, the language we speak, and our culture (Fuchs, 2011). Compared to other modern apes, the human brain has a unique pattern of slow and prolonged development in general, only maturing into an adult brain when reaching 20 years old (Tottenham, 2014). In addition, the human brain continues to restructure itself throughout our lifetime, shaped by our lived experiences, including our lived environment, our illnesses, and our health behaviors (D'Sa & Duman, 2002; Pittenger & Duman, 2008). Culture is passed on from one generation to the next via symbol systems. Unlike our primal/animal instinct, culture can be lost.

In summary, Kant's work would lead to modern cognitivism because he argued that the brain is active and essential to the formation of a sensical, coherent, and consistent stream of consciousness. Kant's work has been widely celebrated as profoundly insightful, original, and foundational to modern studies of consciousness and neuroscience. In his later years, Kant argued that because our understandings of realities are synthesized through our brain, all our experiences are dependent on our culture and language, including our understanding of space and time. Before Kant could undertake a large-scale investigation into such variances, he died. Years later, another scholar, Jean Gebser, took up the effort.

B. Gebser: Multiple Architectures of Awareness

Jean Gebser (1905–1973) learned many languages, including non-European ones such as Hindi, Sanskrit, and some Chinese (Arneson, 2007). He also traveled and lived for extended periods of time around the globe. He was a close colleague to many scholars who traveled the world, compiling anthropological investigations. Based on his life-long studies of different languages, cultures, religions, psychologies, legal systems, arts, philosophies and so forth, Gebser proposed a modified version of Kant's theory (Kramer, 1992b). Gebser realized that there was more than one basic architectural pattern for organizing experience. It is unclear if he believed these differences were caused by cultural variation or if, in the other direction, cultural differences can

be traced to different architectonic constructs. Regardless, Gebser realized that different languages and cultures perceive the world differently and experience different kinds of space and time (Kramer, 1992a). What Kant called the architectonic structure of awareness is similar to the concept of "deep structures" proposed by Noam Chomsky (1969). Gebser (1949–1953/1985) argued that there was more than one kind of structure.

One way to understand what Gebser called "**consciousness structures**" is to think of the human brain as unfinished at birth. The brain of a baby has great potential, but it cannot integrate, organize, and make sense of new information until it has a basic construct. If you think of the human brain as being like the central processing unit of a computer with a basic subroutine, then you can begin to understand what a consciousness structure and its architecture are. A subroutine is an assembly language that enables programs to operate. If a computer has no subroutine, it cannot "read" any language or program.

As a baby is socialized, its brain grows and forms a very basic (simple but profoundly important) matrix or structure that enables the organization and integration of future experiences. At the same time, those experiences also effect the structure of the brain and the way that person perceives space, time, emotion, identity, and other things: the way they see and think about the world. This rudimentary structure will form the basis for how the child will integrate and perceive all new experiences. This includes language itself. The architecture itself changes in structure as language and culture are integrated into the child's mind. Studies of "feral" children who were lost in the wilderness and never taught language by a certain age indicate that after being discovered, they are unable to acquire language (Vyshedskiy et al., 2017). It appears that the biological brain develops through stages and certain types of cognition can develop at only certain times. If these periods are missed, the child will never fully acquire those cognitive and affective abilities (Sakai, 2005; Tottenham, 2014). The basic architecture that enables the synthesis of a coherent and consistent streaming awareness is acquired very early in childhood, which then enables all future sense-making; all future "learning."

In the 20th century, Gebser (1949–1953/1985) discovered that there exists around the world at least four different architectures and consequently four different worldviews: four different ways to experience time, space, and everything that relies on duration and extension – which means everything from dreams and ideas to the perception of empirical objects. Our perception is always already influenced by past experiences, including the language we think in and the culture we grow up in. Since the basic way consciousness is organized is according to temporal and spatial requirements, and because these are dimensions, Gebser argued that the four different worldviews expressly manifest four different formations of these dimensions. They are the magic one-dimensional worldview, the mythic two-dimensional worldview, the perspectival modern three-dimensional worldview, and the postmodern aperspectival or integral worldview.

Finally, culture is not necessarily present for all humans. Gebser (1949–1953/1985) noted that archaic hominids are animal-like, living without made shelter, writing, or art. We know them mostly from skeletal remains. The lifeworld of archaic men is zero-dimensional. Zero-dimensionality means that they do not have a sense of space or time as we moderns know, and therefore no self-awareness as we understand it. Because zero-dimensional hominids did not see themselves as something other than

their environment, they did not experience nature or culture, but rather, simply the world, just as other animals do. As such, the archaic cultural perspective, if it exists at all, is not covered in this book.

C. Kramer: Dimensional Accrual and Dissociation

Eric Kramer further synthesizes Gebser's work on various worldviews with Mumford's (1934/2010) notion of dissociation. Lewis Mumford (1934/2010) traced a process of increasing dissociation through history: Humans gradually separate from nature and progressively build an artificial world that enables them to control and exploit everything, including other people, animals, plants, rivers, lakes, and technology in general. A quality of dissociation is a decrease in emotional attachment to things and people as the number of dimensions to awareness increases.

Dissociation means separation from nature and an increasingly abstract way of thinking. An example of dissociation is the invention and adoption of the mechanical clock, which produces a type of time disconnected from the natural cycles of the actual seasons. Following the natural cycles of seasons, we eat when we are hungry; similarly, we work till the day turns dark or when we get tired. However, the invention of the mechanical clock dissociates us from the natural rhythm, creating a form of virtual time that has no referent to actual light or dark. After the spread and adoption of artificial clock time, we eat and work when "it's time" (as opposed to when we are hungry) and we even began to disregard our bodies and feelings (e.g., exhaustion) because we are not "off the clock" just yet. The clock becomes the new frame that orients not only our understanding of time but also regulates and defines our bodies, feelings, and everyday life.

Theory of Dimensional Accrual and Dissociation (DAD), proposed by Eric Kramer, argues that each worldview manifests through four different modes of *communication* and understanding; one-dimensional idolic communication, two-dimensional symbolic communication, three-dimensional signalic communication, and four-dimensional integral polycentricity (Kramer, 1997, 2013; Kramer & Ikeda, 1998). The integral worldview is a result of cultural fusion (Kramer, 2019). In Chapter 2–5, we will discuss each cultural perspective in detail and explore how they provide more insights into our understanding of health theories and practices. In this Chapter, our goal is to provide a brief overview of the foundational framework. As dimensions accrue, dissociation increases (e.g., identification and care decrease).

1. One-Dimensional Idolic Communication: Magic Consciousness

Scholars argued that Magic culture emerged between 40,000 to 20,000 years ago when prehistoric humans in southern African decorated their bodies and then other surfaces such as cave walls with paintings, depicting everyday life with images of humans and animals (Greenwood & Goodwyn, 2015; McNamara, 2004). Relative to archaic hominids, Magic humans began to dramatically dissociate from the rest of reality/nature and began to develop complex language, tool-making, and ceremonial rituals we call Magic (Greenwood & Goodwyn, 2015). Gebser (1949–1953/1985) called this revolution in human consciousness the dawn of the one-dimensional magic world. Paintings of beasts on cave walls were the beasts who came to life in the flickering torches of the Shaman. Anthropologists have described countless examples of "primitive art" that does not represent things but is "the thing." Naming and depicting "the

thing" give Magic people control over it. In this book, we call this cultural perspective Magic Consciousness.

Magic communities are highly collectivistic. People in a magic community experience everything as a whole and all members' identities are fused as one (Kramer, 2004; Kramer & Ikeda, 1998). For people with Magic Consciousness, when a member of the tribe feels pain, everyone feels pain. They dance, cry, and laugh together. Their totem animal swimming across the river is them swimming (Neihardt, 1932/2014). Because they do not distinguish themselves from other members of the tribe or even other "beings" in their world, they share deep bonds with all beings in their magic community. There is no theater, no performers nor audience. This is because there is no fragmentation between audience and speaker.

For people with Magic Consciousness, their world is taken-for-granted – everything is finished and complete. Initially, Magic culture is still closely identified with natural rhythms and processes. But as dissociation increases, culture, like the ego, emerges as more starkly that which is *not* nature (McNamara, 2004). Bit by bit, magic humans began to attempt to cajole nature, to appease it, to appeal to its forces in order to enhance wellbeing, fertility, and prolong life. Magic systems seek to achieve balance and harmony with the universe in order to enhance health and prolong life. Magic is the first attempt by humans to step out from the rest of nature, turn toward it, and comprehend it as something different from themselves (Greenwood & Goodwyn, 2015). This is the emergence of the one-dimensional structure of Magic Consciousness (Gebser, 1949–1953/1985; Kramer & Algis, 1992).

The earliest forms of magic are attempts to control forces such as illness, fertility, and mortality. Although magic humans still have a very strong emotional attachment and a shared identity with their environment, they also exhibit a realization that the environment is fragmenting into many beings and that they can confront natural forces as things other than themselves. Tools to achieve such desires multiply. Complex magic, idolic incantation, and ritual proliferate. Magic is a tool used to alter reality to suit one's needs and desires – to increase fertility, to make it rain, to cure illness. This indicates the first nascent sense of space, of fragmentation, of directional planning, of a world to be confronted and manipulated.

Magic communication is idolic, meaning that messages and utterances are not dissociated from that which they "reference" (Kramer, 2013). Magic idolic communication has no dissociative space between the sign and what is symbolized. As words are spoken, realities are invoked. Idolic magic communication is meant to directly modify conditions. Reality is evoked and invoked as the talk/act is performed. It uses incantatory speech and acts that invoke and evoke changes that are desired. Spellcasting, ritual movements, chants, actions, and signs are not interpretable or replaceable. There is no space between the spell and its impact. The spell is uttered and either it works (transforms reality), or it does not. Spells are not arbitrary. If you pick up a magic amulet or figurine of a goddess, you are not merely picking up a dissociated symbol of the goddess but the goddess herself. Words have inherent power.

2. Two-Dimensional Symbolic Communication: Mythic Connection

As dissociation increases, it manifests as our ability to perceive a second dimension. As people increasingly dissociate from the taken-for-granted world of Magic Consciousness, two-dimensional symbolic communication manifests nascent spatial thinking such

that messages become ambiguous with both literal and figural meanings simultaneously. Individualism begins to emerge with more emphasis on opinions and interpretations (McNamara, 2004). Communication becomes problematic because meanings are no longer inherent in the words. Storytelling, epic poetry emerges with the linear telling of mythic tales to reconcile differences of meanings and interpretations (Ellwood & York, 1999; McNamara, 2004). These stories define both the speakers' and the audiences' reality and *establish their shared priorities* as a community (Grant, 1998). This is the emergence of the two-dimensional structure of Mythic Connection (Gebser, 1949–1953/1985; Kramer & Algis, 1992).

Idolic communication (e.g., incantation) in the world of Magic Consciousness gives way to more spatial linear storytelling, symbolic communication in the world of Mythic Connection (McNamara, 2004). The age of the great religions commences and is based on lengthy epic poems and histories of the sacred (Eliade, 1959; Eliade, 1964/1998). Time becomes increasingly spatialized in the form of teleological cosmology. Humanity separates from nature. Individuals as historic actors begin to emerge. Concern about the self and concepts such as salvation become prominent. Nascent "progress" toward final judgment days and other terminuses become critical to judgments and spiritual life. With increased spatial thinking in the symbolic world, drama ensues with great tales of the struggle between good and evil (Eliade, 1959). Myths and stories are essential and fundamental in defining and maintaining reality and values shared by all members of the community (Campbell, 1988/2011; Ellwood & York, 1999).

3. Three-Dimensional Signalic Communication: Perspectival Thinking

With increasing dissociation, the ability to perceive the third dimension occurs, the perspectival world (Gebser, 1949–1953/1985). With the emergence of three-dimensional depth space, objects become discrete. In the world of Perspectival Thinking, the dominant mode of communication is signalic (Kramer, 2013). Things are increasingly objectified, meaning that they hold no inherent meaning. As spatial thinking further intensifies, words no longer hold inherent power but are only referential to things. Three-valued logic emerges along with the linear movement of knowledge from thesis to antithesis to synthesis. The relationships between the signifier and the signified are deemed arbitrary and hold little emotional value. Emotional attachment and care that were once rich in the world of Magic Consciousness dissipate in the world of Perspectival Thinking. Nothing is sacred or irreplaceable. People don't care. Meanings in Perspectival Thinking are dependent on the perspectives one takes (Haynes, 2000).

The "beings" that once permeated the world of Magic Consciousness are reduced to material and discrete "objects." As spirit and soul disappear from the world, the "body" becomes an object among other objects. Objects are to be observed and studied. Dissection of bodies becomes the primary path to knowledge. Biological bodies are fragmented into discrete systems. Organs are identified and expertise narrows to specialization on particular systems and diseases. Prothesis, replacement "parts" proliferate. Extraction, storage and transplantation or parts and organs become feasible.

Fragmentation and individuation characterize the three-dimensional perspectival world. Collective community dissolves and modern maladies such as alienation, isolation, and loneliness become epidemic (Kramer et al., 2014). Property and rights become personal. Individualism for humans also occurs and so formalized talk in the

structure of dialectical debate becomes prominent. The emergence of this state of affairs motivates the invention of the modern social sciences as all the founding authors from Ferdinand Tönnies (1887/2017) and Max Weber (1905–1920/2002), to Karl Marx (1935) and Emile Durkheim (1953/2010) were compelled to begin analyses of modern society and the individual's "place," and "situation." Spatial conceptualization of society came to focus on roles, status, hierarchies, power distances, and other aspects of a fragmenting social world. Spatial thinking emphasizes mobility from spatial exploration to social movement within hierarchies. Systems thinking becomes dominant with sub- and super- systemic hierarchies. Identity becomes flexible, even arbitrary, and can encounter a crisis. Stark individualistic, subjective relativity is a result of three-dimensional signalic communication and its quality of being arbitrary.

4. Four-Dimensional Integral Polycentricity: Integral Fusion

Magic Consciousness, Mythic Connection, and Perspectival Thinking are three different cultural perspectives. Each represents a distinctive approach to understanding one's reality and its relationship with language and culture. These cultural perspectives can be incompatible. Either a person's body is fused with other sacred spirits and life forces in the universe (under Magic Consciousness), or it is understood to be a symbolic gift of love and life by one's ancestors (under Mythic Connection), or it is a material object that can be dissected and studied (under Perspectival Thinking). For a person with Magic Consciousness, dissecting a body can be disrespectful, dangerous, and even unthinkable. For a person with Perspectival Thinking, believing that a body is fused with spirits and needs to be in harmony with the universe to be healthy sounds silly and superstitious.

Kramer (2013) used the term "dimensional accrual" to highlight that the people with access to more dimensions continue to have the capacity to understand individuals with worldviews that have fewer dimensions, but often they do not. Or, if they do, they apply a more dissociative attitude to those forms. One result is cynicism. Although a person with Perspectival Thinking can understand, manipulate, and even exploit the thinking of people with Magic Consciousness (see also Exploitation Exists Only in Perspectival Thinking in Chapter 13), a person with Magic Consciousness may not immediately understand a Perspectival person's calculative self-interest, in part because it is foreign to them. This is the layering effect of cultural perspectives (see also Accrual of Cultural Dimensions in Chapter 5). In our modern world, in which Perspectival Thinking predominates, all cultural perspectives are co-present as potential and as essential aspects of human consciousness. However, Magic Consciousness and Mythic Connection tend to be latent. Nevertheless, each cultural perspective holds capacities and potentials we need for survival but which we may not yet understand. For now, the key point is that these three cultural perspectives have a layering effect on one's understanding and appreciation of realities.

More importantly, although the numbering of dimensions of each cultural perspective may appear to give a sense of ranking or hierarchy, it is important *not* to mistake the numbering as an indicator of developmental or linear progress of human societies or cultures. They represent different modes of understanding one's reality and the roles of culture and language. Each cultural perspective serves as one's architectural structure that governs how all other sources of information are combined to create a synthesized, coherent meaning. One is not "better" than the other. In fact, many scholars have

argued that stronger identification with worldviews of Magic Consciousness and Mythic Connection is necessary to avoid the increasing deterioration and depletion of our world, which is dominated by Perspectival Thinking (Greenwood & Goodwyn, 2015; Kramer et al., 2014; McNamara, 2004). We will revisit this issue throughout the book.

An Integral Fusion worldview is a result of cultural fusion among the cultural perspectives of Magic Consciousness, Mythic Connection, and Perspectival Thinking. Essential to Integral Fusion is one's ability to view different perspectives with equal care, respect, and validity. As a cultural perspective, Integral Fusion is **polycentric** because it not only recognizes but also *appreciates* other cultural perspectives. This understanding of the ever-present functioning and ontogenesis of Magic, Myth, and Perspectivism through their differences, and their vitality in our lives, is integrality. It has profound emotional, spiritual, *and* analytical aspects. Just as two or more adjacent colors change each other, Magic emotion, Mythic story, and Perspectival measure reveal each other's qualities by contrast and complement through time.

Integral Fusion does not adopt a fixed, dominant cultural perspective that marginalizes all Others. Nor does it dislocate or eliminate others. There is no modern ideological category (e.g., the "subaltern") in an Integral Fusion worldview as all perspectives are taken into consideration, with equal weight and care. An Integral Fusion worldview is reflected in one's ability to integrate and synthesize these diverging cultural perspectives and reconcile the tensions between them. However, rather than a layering of other cultural perspectives, cultural fusion always leads to something *new*, something that is not the direct derivative of the source cultures. It creates a *new* cultural perspective that is influenced by all cultural perspectives but also unique in its blending of cultures (Kramer, 2000). An Integral Fusion worldview is a result of cultural fusion *without* the erasure of the original cultural self (Kramer, 1997, 2000, 2008). Through social interactions, new forms (of music, cuisine, art, literature, science, history, fashion, business models…) of cultural fusion proliferate.

An Integral Fusion worldview is able to see by *seeing through* the different cultural perspectives, appreciating their strengths, understanding their limitations, and developing unique and innovative blends that best accommodate everyone's needs. An Integral Fusion worldview can be a result of intentional efforts or organic, unexpected processes of intercultural encounters. It is not inherently "better" than other cultural perspectives. Cultural fusion does not guarantee a "better" result. Nevertheless, because an Integral Fusion worldview promises infinite possibilities and potentials through the blending of cultural perspectives, its flexibility and diversity are some of the greatest strengths in addressing problems faced by our society. In this book, we will explore why cultural fusion is valuable in helping our communities to meet the challenges of our times in healthcare settings and in health policies.

III. Learning Objectives

There are three primary learning objectives that guide our focus for this book. First, we will challenge our readers to see culture beyond racial and ethnic groups. We have included different conceptualizations of culture (e.g., culture as group, as speech

community, as worldview, and as a living process), exploring how these distinctive approaches may allow readers to identify different problems and develop different solutions. In addition, we encourage our readers to reflect and consider how they may hold different cultural perspectives on different issues/topics, shaping their behaviors and responses accordingly.

Second, by covering a wide range of topics in cultural studies, public health, health communication, and health policies, our goal is to help the readers develop the skills to recognize and challenge the cultural perspectives inherent in theory or practice. In addition, by contextualizing cultural groups' past experiences, we hope that readers will reconsider the effectiveness and appropriateness in how we conceptualize barriers and facilitators of health and healthcare services.

Third, our goal is to help our readers develop a conceptual framework that allows them to critically and reflexively examine the issues at hand, including health theories and practices. Scheper-Hughes (1992) commented, "We cannot rid ourselves of the cultural self we bring with us into the field any more than we can disown the eyes, ears, and skin through which we take in our intuitive perceptions about the new and strange world we have entered" (p. 28). In other words, we cannot "objectively" interpret or understand the world as our subjectivity is embedded in our consciousness, nor can we truly unlearn and forget about our cultural selves (Liu & Kramer, 2019). Nevertheless, as we become more aware of cultural perspective(s), we can learn to appreciate differences and develop repertoires that allow us to identify creative, effective and appropriate strategies to achieve mutually agreeable solutions.

Finally, we also face the limits of our own cultures and languages. Although both authors have extensive background and training in different cultures, our training in social science inevitably reinforces our Perspectival Thinking, which requires analytical reasoning. There may be moments that we misappropriate analytical concepts when addressing other cultural approaches and perspectives. In addition, as citizens of democratic societies, we also recognize that some of our suggestions and recommendations are not applicable to cultures and societies where its citizens are not treated to be equal and free and do not have the agency and control over their behaviors and life destinies. We regret that we were not able to give sufficient depth and analysis to address their struggles and suffering.

As we complete our chapters during this historical time of a global pandemic, we felt a sense of purpose. We hope you enjoy this book as much as we do.

IV. Additional Resources

A. Key Terms and Theories

health promotion
healthcare delivery
lived experience
transformative technologies
pan-evolution
risk communication