《傳播與社會學刊》，（總）第 58 期（2021）：1–28

學術對談

健康傳播在亞洲地區理論化的機遇與挑戰

對談人：泰瑞．湯普森、莫漢．杜塔、張皪元
編　輯：張皪元
翻　譯：程羽加、蘇幼真

泰瑞．湯普森教授
（Prof. Teri L. Thompson）

「沒有理論基礎，我們做任何研究的類推性都會受到極大的限制。從這個角度來看，理論甚至比樣本本身和生態效度更重要。舉例來說，因為存在共同的理論架構，我們才可以將糖尿病的研究結果概化至愛滋病或新型冠狀病毒研究。這種以理論概推的方式使我們得以充分發展健康傳播領域。所以我們應該牢牢記住，理論是我們研究的根本。」

泰瑞．湯普森，美國戴頓大學藝術與科學學院傳播學榮休教授。研究興趣：健康傳播、性別與傳播。電郵：tthompson1@udayton.edu
莫漢．杜塔，紐西蘭梅西大學傳播學系院長講席教授。研究興趣：國際健康傳播、批判文化理論、貧窮與健康照護、底層研究與對話、公共政策及參與式社會變遷。電郵：M.J.Dutta@massey.ac.nz
張皪元，香港浸會大學傳播系副教授。研究興趣：健康傳播、科技中介傳播。電郵：leannechang@hkbu.edu.hk

莫漢．杜塔教授
（Prof. Mohan J. Dutta）

「就亞洲地區的健康傳播理論化而言，我把『轉型』一詞作為思考的基礎。我們應該認真考慮如何以亞洲的地緣與特殊性，提出這樣的問題：『從亞洲地區出發進行理論化，在亞洲地區之中進行理論化，以及從亞洲地區的實證觀察導出對情境的理論化，到底意味著什麼？』我將我的答案置於我所看到的霸權健康傳播理論以及亞洲內部健康傳播理論化的陷阱之中。」

Communication and Society, *58* (2021), 1–28

Dialogue

Challenges and Opportunities of Theorizing Health Communication in Asia

Discussants: Teri L. THOMPSON, Mohan J. DUTTA, Leanne CHANG
Editor: Leanne CHANG
Translators: Yujia CHENG, Youzhen SU

Abstract

This dialogue features Dr. Teri Thompson, an outstanding scholar in health communication and Editor-in-Chief of *Health Communicatio*n, and Dr. Mohan Dutta, a leading health communication scholar with a research focus on the Global South. Dr. Thompson describes the significance and scope of health communication theories and critical ethical issues tied to health communication research. Dr. Dutta shares his views on theorizing health communication in Asia and relevant challenges and opportunities. Dr. Dutta proposes the use of hegemonic communication theories and Asian imaginaries to advance theoretical development in culturally rich and diverse Asia. Both scholars provide advice to young Asian scholars who are interested in pursuing health communication research.

Citation of this article: Thompson, T. L., Dutta, M. J., & Chang, L. (2021). Challenges and opportunities of theorizing health communication in Asia. *Communication and Society*, *58*, 1–28.

Teri L. THOMPSON (Professor Emeritus). Communication, College of Arts and Sciences, University of Dayton. Research interests: health communication, gender and communication.

Mohan J. DUTTA (Dean's Chair Professor of Communication). School of Communication, Massey University. Research interests: international health communication, critical cultural theories, poverty and health care, subaltern studies and dialogue, public policy and participatory social change communication.

Leanne CHANG (Associate Professor). Department of Communication Studies, Hong Kong Baptist University. Research interests: health communication, technology-mediated communication.

泰瑞．湯普森教授簡介

泰瑞．湯普森教授是美國戴頓大學（University of Dayton）傳播學系的榮譽教授。她擔任健康傳播領域旗艦期刊*Health Communication*的總編輯已經超過33年。湯普森教授的研究領域包括健康傳播、性別與傳播。她近期的研究包括訊息對器官捐贈偏好的影響、喪親的因應策略，以及倫理與健康傳播。她出版過八本包括專著和合著在內的專書，並曾發表七十多篇學術文章。湯普森教授在健康傳播領域的傑出貢獻，令她獲得美國國家傳播協會（National Communication Association）頒發的「2009年度傑出健康傳播學者獎」（Outstanding Health Communication Scholar Award）。

莫漢．杜塔教授教授簡介

莫漢．杜塔教授是紐西蘭梅西大學（Massey University）傳播學系的院長講席教授，以及文化核心途徑研究與評估中心（Center for Culture-Centered Approach to Research and Evaluation）的主任。杜塔教授的研究包括國際健康傳播、批判文化理論、貧窮與健康照護、底層研究與對話、公共政策及參與式社會變遷。他曾獲得美國國家傳播協會的「2017年度傑出健康傳播學者獎」，並入選為國際傳播學會（International Communication Association）院士。杜塔教授現為*Journal of Applied Communication Research*及*Frontiers in Health Communication*的總編輯。

TT ：泰瑞．湯普森
MD：莫漢．杜塔
LC ：張皪元

LC： 健康傳播聚焦於解釋現實生活中與健康相關的問題，它的實用導向可能會令一些人懷疑理論在這個領域的重要性。可否請您與我們分享為何理論在健康傳播是重要的？

TT： 我們很幸運看到理論在健康傳播領域得到了很大的發展。理論的確是健康傳播研究中不可或缺的重要一環。雖然我不是每個領域的專家，但是我認為在任何社會科學領域裡，理論的重要性都是不言而喻的。沒有理論基礎，我們做任何研究的類推性都會受到極大的限制。從這個角度來看，理論甚至比樣本本身和生態效度（ecological validity）更重要。舉例來說，因為存在共同的理論架構，我們才可以將糖尿病的研究結果概化至愛滋病或新型冠狀病毒研究。這種以理論概推的方式使我們得以充分發展健康傳播領域。所以我們應該牢牢記住，理論是我們研究的根本。

LC： 您剛剛提到理論在健康傳播領域得到很大的發展，可否請您談談健康傳播理論的範疇？

TT： 說到健康傳播理論的範疇我很有感觸，因為我剛寫完一本健康傳播的書。我想在這裡講一些健康傳播領域可能涉及到的理論。我覺得這些理論對於研究人員和從業人員來說是很重要的，我希望諸位可以思考如何將它們應用到自己的研究之中。除了理論本身，還有一些在理論與實踐上都很重要的概念，這些概念對研究健康訊息和受眾分層相當有意義。我認為我們需要關注的概念包括：主題、訊息與受眾的投入（involvement with the topic, with the message, and with the audience）、健康識讀（health literacy）、控制點（locus of control）、自我監控（self-monitoring）、刺激尋求（sensation seeking），以及抵抗傾向（reactance proneness）。我希望我分享的這些概念能夠幫助你們思考如何將它們整合到你們的研究當中。除此之外，我們還可以用吉爾．山崎（Jill Yamasaki）書裡的一段話來思考理論與方法的關係：「鑒於健康傳播詮釋與批判取向的本質，把理論與方法論（methodology）或是表徵（representation）分開並不總是可行、實際或是值得期盼的。」

談到具體的理論內容，我覺得我們應該先聚焦於人際關係層面，這包括雙人（dyads）與團體（groups）溝通。人際健康傳播理論通常是第一個被關注的議題，這部分包括家庭在醫療保健服務情境下的互動，以及另一個很重要的概念是醫患互動（provider-

patient interaction）的理論架構。就人際健康而言，有三個特別重要的理論：傳播適應理論（communication accommodation theory）、傳播隱私管理理論（communication privacy management theory），以及道德協商理論（the theory of negotiated morality）。我希望學者能夠思考如何利用這些理論，將它們融入你們的研究當中。至於我們若是想評估家庭在醫療保健服務情境下的互動，我可以想到四個重要的理論：家庭壓力與應對的雙重ABC-X模型（the Double ABCX model of family stress and coping）、奧爾森的婚姻和家庭系統環繞模型（Olson's circumplex model of marital and family systems）、不協調培育理論（inconsistent nurturing as control），以及情感交換理論（affection exchange theory）。醫患互動的理論架構在健康以外的其他領域也有很多的應用，但它們在健康傳播領域內的應用仍是非常重要的。學者們應該注意研究醫患溝通的原型理論，還有以患者為中心的理想溝通方式、關係模式與社會及公共行為。

很多關於影響過程（influence processes）的研究觀點也跟健康傳播有關。我們知道很多傳播行為，尤其是健康傳播行為牽涉到影響的過程。因此，我們必須討論訊息處理和認知理論（information-processing and cognitive theories）、情感影響理論（theories of affective impact）、行為理論（theories of behavior）和訊息效果理論（theories of message effect）。還有一些關於訊息效果的理論也值得參考，因為它們都跟健康傳播領域有關，包括了議題設定（agenda setting）、涵化理論（cultivation theory）、敘事參與理論（narrative engagement framework）、框架理論（framing theory）、免疫理論（inoculation theory）、使用與滿足理論（uses and gratification theory）和媒體互補理論（media complementarity theory）。

從組織與社會的層面來看，我們應該關注社會心理學理論、公共關係理論、不確定性理論和文化理論。另外，我認為我們應該要思考數碼媒體科技帶來的影響，這包括了兩個重點：線索路徑（the cue route）、行動路徑（the action route），以及與這兩個路

徑有關的一些理論。最後，我們必須思考健康傳播的前景，包括更多對多階與系統導向的思考、縱向理論發展、轉化應用與推廣（translational implementation and dissemination）、管制科技整合（integration with regulatory science），以及對虛假訊息的理論研究。雖然目前我們有在研究虛假資訊，但我們並不怎麼理論化它。如果能對虛假訊息進行理論研究，聽起來不是很有趣嗎？學者們該如何做到這一點呢？我對此十分期待。

LC： 您覺得健康傳播哪個子領域的理論化最困難呢？

TT： 我認為從各種角度來看，醫患溝通都是屬於比較難以理論化的領域。過去有很多關於醫患互動的研究都沒有理論框架。直到現在，也只有部分學者如彼得．舒爾茨（Peter Schulz）及蔣少海（Shaohai Jiang）曾探討的一些關於醫患溝通研究的原型理論。他們提出的概念和研究可以幫助我們在醫患溝通的脈絡下理解這些理論。

LC： 傳播學研究向來注重研究倫理，而倫理議題在健康傳播領域格外重要，因為相關研究可能會直接影響個人和社群的健康。您認為健康傳播中最關鍵的倫理問題是什麼？

TT： 倫理問題在任何研究領域中的影響都是不可忽略的，當我們關切和健康有關的傳播議題時，對於倫理的考量一定會浮現。我們必需注意在理論架構和指導準則層次的倫理考量，包括善益原則（beneficence）、對自主權的尊重、平等、效用與真實性。尤其是在臨床和醫療組織的研究情境下，倫理和許多議題——諸如事實陳述、診斷不確定性、敏感話題、吹哨（whistleblowing）以及越界都息息相關。此外，在新興數碼與社交媒體的情境下，我們也能看到很多跟健康傳播相關的倫理問題，包括對公平、自主與隱私的關切、醫療品質，還有潛在傷害。我認為健康宣導活動，即在健康傳播和社會行銷領域的倡導活動，是我們啟始研究倫理的地方。健康宣導活動的相關倫理議題存在於受眾分層、貼標籤、污名化、風險／恐懼／誘導、責任訴求、正向社會價值與剝削之中。

LC：近幾年來，健康傳播研究在亞洲地區蓬勃發展，作為一名曾在不同亞洲文化脈絡下進行健康傳播研究的學者，可否請您與我們分享您對健康傳播在亞洲地區理論化的看法？

MD：就亞洲地區的健康傳播理論化而言，我把轉型（transformation）一詞作為思考的基礎，這是因為我對慣性含義（habitus meaning）這個問題非常感興趣。也就是說，我們應該認真考慮亞洲的地緣與特殊性，提出這樣的問題：「從亞洲地區出發進行理論化（theorize from Asia），在亞洲地區之中進行理論化（theorize in Asia），以及從亞洲地區的實證觀察導出對情境的理論化（theorize about contexts），到底意味著什麼？」我將我的答案置於我所看到的霸權健康傳播理論以及亞洲內部健康傳播理論化的陷阱當中，或者，置於更廣的霸權傳播理論框架中。我將解釋我如何主張存在於亞洲大學評鑑遊戲裡的殖民化架構（colonizing structures），從實質上阻礙了我們在亞洲脈絡下進行有意義的理論化。從這個角度來說，我更想強調制度上的障礙，以及我為何認為評鑑的本身就是一種嚴重阻礙理論化的殖民過程。之後，我想探索將「亞洲想像」作為健康傳播理論化的基礎意味著什麼。

LC：您剛才提到，亞洲地區的健康傳播理論化存在著霸權主義的殖民化結構，請問我們應該如何理解「健康傳播理論中的霸權主義」這個概念呢？

MD：回答這個問題之前，我們首先需要思考一個問題：理論是由誰定義的？回顧歷史中所有的理論化進程，大部分，甚至可以說超過九成的傳播學理論化，包括了健康傳播的理論化，都發生在北方世界[1]（Global North）。所以就理論和理論化的版圖而言，我們可以看到「誰來理論化」、「誰被理論化」以及「哪些部分被理論化」這些方面都存在著根本的不平等。

我打算借用我最近的論文*Theorizing from the Global South: Dismantling, Resisting, and Transforming Communication Theory*來闡述這種不平等。這篇論文的主要論點是，南方世界（Global South）的理論化，往往只是複製以西方白人為主的理論化過程。

於是，理論建構的本質變成了測試那些源自北方世界邏輯而形成的理論，卻從未真正質疑構成這些理論的根本原則與邏輯。在我的另一篇論文*Whiteness, Internationalization, and Erasure: Decolonizing Futures from the Global South*裡，我質疑目前大部分關於去殖民化的聲音，只是援引並再製以美國白人為中心的框架，而並沒有真正探索這些框架是否適合南方世界的情境脈絡，還是它們僅協助延續了殖民化的過程，並讓理論化過程的根本不平等不斷再現。

談到健康傳播中的霸權主義，我必須強調這種特殊的理論化邏輯是白人優越邏輯的體現，因為它描繪出白人文化價值觀對「人類是什麼」以及「人類社會運作的模式是什麼」的根本設想。在這種邏輯裡，以美國為中心的白人文化價值觀和資本主義的邏輯聯繫在一起，支配著我們將健康概念化為一種個人商品，而忽略了對關係性的研究、對社群的重視、對人與生態系統之間關係的探索，以及對人們生活範圍外更宏觀結構的探討。我認為，這些探討必須置於資本主義對亞洲世界的衝擊背景下，特別是自1980年代以來，新自由主義不斷衝擊亞洲世界，並在90年代升溫。個人化在資本主義的衝擊中得以被複製，以致社會將威脅人類健康和生活的利益追逐、勞動剝削和市場基本主義放在首位。在這樣的理論化過程中，你會看到資本的邏輯如何反覆再製，並體現了以美國白人為中心的健康傳播理論架構。亞洲大學裡的健康傳播研究成為了複製白人框架的「重災區」，並且成為執行全球新自由資本的「前哨站」。

LC：您能更詳細闡述一下「亞洲大學裡的健康傳播研究成為了複製白人框架的重災區」這個觀點嗎？您之前也有提到「亞洲大學的評鑑遊戲」，這包括了對期刊影響指數、排名及發表數量的重視。這些評鑑模式在亞洲健康傳播領域的理論化中，到底扮演什麼樣的角色？

MD：亞洲的大學在對期刊論文數量的追求和在對「什麼是知識」、「什麼可以算知識」的闡述上，將對白人價值觀的渴望發揮得淋漓盡致。

這樣的評鑑模式是新殖民主義的終極形式，它讓以美國為中心的期刊霸權與知識霸權得以延續。因為這些期刊刊登的多數是以白人學者為主的美國研究，而亞洲學者為了能在美國的學術期刊上發表論文，競相不加批判地複製以美國為中心的研究模式並引用美國白人學者的論文。換句話說，亞洲情境下的研究邏輯就是白人邏輯的複製品。在亞洲的大學裡，我們因再製（reproducing）和流傳隱含白人優越性的構念而獲得升職或獎勵。這種評鑑模式最終就是讓白人優勢的種族意識形態得以廣為傳播，而與此同時，這種模式也貶低了與亞洲人群日常生活息息相關的文化背景及表述的價值。文化經常被當作一種事後想法，或者被當成散佈這些霸權基本主義的一個變項。例如，「個人主義—集體主義」常常被拿出來當成一個構念，但其實這種將文化視為變項的方式只是抹滅了文化的多樣性。文化敏感度成為一種再製霸權邏輯及貶抑（devaluing）文化為一個變項的手段，這破壞了它作為集體化、連結關係性的存在。這整個結構主要是由體現白人霸權主導的跨國排名體制而造成的。我在國立新加坡大學當傳播系系主任時，曾經指導過亞洲學者，也與這些強制要求以排名為導向的評鑑模式抗爭過。我清楚地意識到，若要創建亞洲健康傳播研究的根基，必須先破除這種排名制度。我們必須認識到，這種白人優越的評鑑遊戲會阻礙所有亞洲地區理論化的努力。很多亞洲地區主要研究機構的學者，會因為在以美國為中心的學術期刊上發表論文而得到獎勵，這有助持續鼓勵以及散佈以美國為中心的邏輯觀。當我回顧我編輯的期刊並思考這些問題的時候，我發現，無論在該期刊上發表論文所需要的根本邏輯，或是像「什麼可以被認為是理論」的問題，都在延續這種白人優越性，除非我們積極干預瓦解它。到頭來，這些評鑑遊戲根本只是再現和具體化白人優越性的系統，並將它的影響力延伸到亞洲地區，然後得到所謂「國際化」的成就。我認為這種「國際化」的本質，只是重塑和再製西方理論化的霸權。

LC：在您看來，亞洲學校努力想達成的國際化，其實只是美國化，或者更批判地說，是被以美國為中心的白人文化殖民化。那麼，您

所謂的以建立「亞洲想像」作為健康傳播理論化的基礎，這是什麼意思呢？

MD：我認為亞洲想像是關於反殖民主義的未來想像。這種想像根植於20世紀50年代的反殖民主義抗爭，在新興後殖民主義國家崛起的背景下，這些抗爭塑造了許多亞洲想像。因此，我們需要思索如何在充滿多元歧異的亞洲，建構南方世界（Global South）對健康和福祉的想像能力。這些處於南方世界的亞洲國家，該如何想像將社區自主權、關係紐帶、家庭框架、群體利益和公眾利益這些觀念作為公共資源。我們如何通過促進南方世界之間的知識流動來建立專屬於南方世界的理論？我們如何拆解新自由主義的資本邏輯和隱含其中的極端資本主義霸權，以及它們對個人主義的膚淺追求導致不平等不斷再製的現象？我們該如何構建關於健康傳播的未來，使那樣的未來能夠起到反資本主義的效果？需注意的是，從南方世界出發的理論化應該要明確地反殖民主義與反資本主義。我舉一個南方世界關於社區主導健康（community-driven health）的例子。現在已經有很多社區菜園和種子銀行的範例，在那裡社區將「健康」最基本的形式，定義為社區對食物的基本自主權，即社區擁有近用健康食物的權利。對這些社區而言，健康即食物，而社區以擁有農業所有權的形式來維持生計，並以此抵抗農業企業的殖民化。透過對社區所有權和主權的主張，這些可持續農業為健康與福祉提供了一種變革模式。遵循這原則，我們可以持續思考如何從根本上用一種反殖民的思維，去觀察和組織亞洲的健康傳播。

LC：您剛才提到亞洲健康傳播的發展應採用去殖民化的途徑，即亞洲學者應多加思考如何提出具亞洲文化獨特性及相關性的理論概念，減少對美國主導研究模式的複製與依賴，因為那些框架在亞洲當地的脈絡下可能不太適用。從這個角度，可否請您多談談在亞洲地區健康傳播研究所面臨的挑戰？

MD：關於這個問題，我的看法是在資本主義和新自由極端主義的衝擊下，健康傳播在亞洲地區面臨的挑戰，就某種程度而言，是將「結構」（structure）放在首位的必要性。從這次的新冠肺炎疫情

中，我們可以看到這個問題帶來的巨大挑戰。亞洲地區的都市化發展（Asian urbanization）有點是為了在西方眼中看起來顯得美觀又高尚，但在這背後實際上是極大的貧富差距和對底層的剝削，在那裡我們可以發現嚴重的健康不平等。在這種脈絡下，文化核心途徑（culture-centered approach）探討我們為何需要將文化視為構成情境的一部分，強調用社區的能動力（agentic capacity）去尋求解決方法，並且對威脅人類健康福祉的結構提出挑戰。同時，這意味著我們應當遠離所謂的亞洲本質主義，也就是那些你會在「亞洲價值觀」對話裡看到的，用文化當話術以維持精英結構的權力與控制。為了解決健康不平等的問題，我們需要構想出建立社區發聲（community voices）基礎結構的一些方法，這樣才能使社區成員享有健康與福祉。

LC：的確，我們看到印度的第二波新冠肺炎疫情，窮人無法近用醫療資源，他們的需求與聲音也無法被聽到。這導致醫療體系資源的分配，主要以精英的思維運作，而沒有納入地方的聲音。您提到的文化核心途徑，就是在探討三個元素——結構、文化和能動性對群體健康的影響。然而，機遇與挑戰共存。在亞洲背景下，您認為健康傳播的理論化有什麼機遇嗎？

MD：我將健康傳播理論化這件事等同於結構的轉型化。轉型的結構讓我們得以平等分配基礎結構的資源，例如收入財富、生存機會、資訊、證據以及知識的平等。這些資源的平等分配都與建立溝通平等有關，即人民應當享有資訊的資源，有提出對知識的主張和創造證據的資源，有尋求代理、作決策和發聲的資源。只有當我們建立傾聽的基礎結構，那些我們試圖協助與合作的社區，才能以真正有意義的方式說出他們的聲音，讓他們被聽到，從而真正促進他們的健康與福祉。健康傳播應採取由社區主導的草根組織形式，才能持續對健康和福祉作出努力。健康傳播應採取建立「溝通基礎結構」（communication infrastructures）的形式，讓社區之間建立更堅固的關係網路，以爭取更好的健康和福祉。同時，社區應擁有溝通的主權，他們應該擁有並意識到對溝通基礎結構

的所有權，在那種結構下他們可以表達心聲，可以跨空間連結，可以從不同的節點發出他們的聲音。

LC： 健康傳播研究經常向社會學、心理學、公共衛生以及統計學等學科取材。根據您的研究經驗，可否請您談談健康傳播跨學科合作中的挑戰以及該注意的地方為何？

MD：我覺得這是一個很好的問題。我認為挑戰在於，究竟健康傳播能為跨學科的對話帶來什麼。對我來說，當我進行和建築師或農業工程師合作的跨學科研究時，我覺得挑戰在於先找出什麼是真正的問題，然後從那個問題出發，去思考健康傳播可以幫到什麼忙。幾乎所有的問題，總是可以找到一個跟傳播相關的面向值得探討。對我來講，這種對話的精神，這種想要對話、想要理解他人如何看待問題的開放性，會影響我們如何將自己的理解帶入這些合作當中，這也是跨學科合作所強調的。在我自己的工作中，我引入了一種「基於正義」(justice-based) 的健康傳播研究取徑。這讓我的跨領域合作不只局限於學術研究，更延伸到與社會運動者、倡議者、社區研究人員和社區組織者的關係。為了解決健康不平等的問題，我們必須改變不平等的結構，這塑造了我跨領域研究工作的本質。

LC： 近年來，越來越多年輕的亞洲學者加入健康傳播領域並致力健康相關研究，兩位教授能否為他／她們提供一些建議？

TT： 我認為一個很重要的方面是社交網絡 (networking)。雖然這是一個偏西方的詞，但對年輕的亞洲學者來說極為重要。我印象很深的一點是，年輕學者，特別是那些我接觸過、來自中國的年輕學者，他們較少得到前輩的指導 (mentoring)，這有點超乎我的意料之外。所以，我會鼓勵他們多拓展跨社交網路、跨學科和跨研究領域的人脈，以努力克服這種缺乏前輩指導的問題。

MD：我很喜歡湯普森教授所說的擴展社交網絡的想法。至於我對亞洲年輕學者想講的第一點就是：「要相信你自己」。「相信自己」指的是要相信你所處的社會環境，相信它有東西可以教你。不要讓以美國為中心的學科霸權主宰了你應該學習什麼以及該如何學習。

你沒有必要為了在學界求生存和建立理論，就不斷複製那些大抵由美國白人樣本實證分析得出的白人構念。你應該密切通過實證觀察你所處的情境脈絡，還有身處其中的健康生活體驗。同時你也應該注意根植於情境脈絡裡的健康含義，如何成為個人、家庭和社區協商健康的基礎。不要盲目複製諸如個人主義—集體主義等化約主義（reductionist）的構念，這些構念只是拿白人去脈絡化（decontextualized）的視角強加諸於不同文化，然後再比較它們。這是我想講的第一個點。順著這個思路，第二個建議就是，密切關注日常生活的物質性（materiality）。你應該認真看待日常生活中的經驗主義，並透過它來建立理論。這意味著不要只提出殖民化結構強加給你關於特定理論的假設，然後問：「我該怎麼複製這些假設來解決這個問題？」相反的，你應該從實證關切你所處情境中看到的東西，並且尊重那個情境，讓經驗主義從情境脈絡中浮現，由它來指引你建構及發展理論。所以，我們該如何認真對待「亞洲」這個充滿多樣性與碎片化的概念，在亞洲脈絡裡進行類推、比較與綜述呢？舉例而言，普世分配（universal distribution）的社會主義理念存在於多個亞洲經濟體的醫療概念之中。這種對普世近用（universal access）的重視，來自於集體。很明顯的，我們正處於健康傳播學科史上的某個重要時刻，我們必須盡快讓這門學科去殖民化。而去殖民化從根本上而言，就是要撤銷那些白人文化優越架構下流傳的概念與方法，改由亞洲脈絡出發。為了實現這一切，目前所要做的事便是積極促使亞洲大學的去殖民化。

註釋

1 「北方—南方世界」常被用來表示經濟發達國家和發展中國家在社會、經濟和政治上的分歧。通常，「北方世界」泛指經濟發達的國家和地區，如美國、英國、加拿大、西歐國家和亞洲發達地區；「南方世界」泛指經濟欠發達的發展中國家，如非洲國家和亞洲一些地區。

泰瑞．湯普森教授著作選

Thompson, T. L. (2006). Seventy-five (count'em—75!) issues of *Health Communication*: An analysis of emerging themes. *Health Communication*, *20*, 117–122. Retrieved from https://doi.org/10.1207/s15327027hc2002_2.

Thompson, T. L. (2011). Hope and the act of informed dialogue: A delicate balance at end of life. *Journal of Language and Social Psychology*, *30*, 177–192. Retrieved from https://doi.org/10.1177/0261927X10397150.

Thompson, T. L., & Harrington, N. G. (Eds.). (2021). *The Routledge handbook of health communication* (3rd ed.). London: Routledge.

Thompson, T. L., Robinson, J. D., & Kenny, R. W. (2003). Gender differences in family communication about organ donation. *Sex Roles*, *49*, 587–596. Retrieved from https://doi.org/10.1023/B:SERS.0000003129.25173.ad.

Thompson, T. L., & Schulz, P. J. (Eds.). (2021). *Health communication theory*. New York: John Wiley & Sons.

莫漢．杜塔教授著作選

Dutta, M. J. (2008). *Communicating health: A culture-centered approach.* Oxford: Polity.

Dutta, M. J. (2011). *Communicating social change: Structure, culture, and agency*. London: Routledge.

Dutta, M. J. (2012). *Voices of resistance: Communication and social change.* West Lafayette: Purdue University Press.

Dutta, M. J., & Kreps, G. L. (Eds.). (2013). *Reducing health disparities: Communication interventions*. New York: Peter Lang.

Dutta, M. J., & Zapata, D. B. (Eds.). (2018). *Communicating for social change: Meaning, power, and resistance*. Singapore: Springer.

參考文獻

Dutta, M. J. (2020). Whiteness, internationalization, and erasure: Decolonizing futures from the Global South. *Communication and Critical/Cultural Studies*, *17*, 228–235. Retrieved from https://doi.org/10.1080/14791420.2020.1770825.

Dutta, M. J., & Pal, M. (2020). Theorizing from the Global South: Dismantling, resisting, and transforming communication theory. *Communication Theory*, *30*, 349–369. Retrieved from https://doi.org/10.1093/ct/qtaa010.

Thompson, T. L., & Schulz, P. J. (Eds.). (2021). *Health communication theory*. New York: John Wiley & Sons.

Yamasaki, J. (2021). When theory and method intertwine. In T. L. Thompson & P. J. Schulz (Eds.), *Health communication theory* (pp. 42–63). New York: John Wiley & Sons.

本文引用格式

泰瑞．湯普森、莫漢．杜塔、張皞元（2021）。〈健康傳播在亞洲地區理論化的機遇與挑戰〉。《傳播與社會學刊》，第58期，頁1–28。

Academic Dialogue with **Teri L. THOMPSON** and **Mohan J. DUTTA**

Challenges and Opportunities of Theorizing Health Communication in Asia

TT : Teri L. THOMPSON
MD: Mohan J. DUTTA
LC : Leanne CHANG

LC: Health communication research focuses on addressing real-life health problems. Its pragmatic orientation may make many people wonder the significance of theory in this field. Could you share with us why theory is important in health communication?

TT: We have seen, fortunately, a lot of development in health communication in terms of the role of theory. Theory is essential, and I'm going to say that this essential role applies to all fields of study, though that probably is not true; I'm not really an expert on all fields of study. But it certainly is in all aspects of social science, communication, and health communication. Without theory, the generalizability of any research that we do is woefully limited. Theory is even more important than the sample and ecological validity for the generalizability of the research, in my humble opinion. For example, if I'm able to generalize the findings from a study on diabetes to a study on HIV or COVID-19 because of shared theoretical frameworks, the field is then built much more adequately. That's an important point for us to keep in mind. Theory should be the starting point for our research.

LC: You mentioned that many theoretical explanations have been developed in the field of health communication. Could you elaborate more on the scope of health communication theories?

TT: The questions about the scope of health communication struck me because I just finished doing a book on health communication theory. I'd like to tell you a little bit about the various theories that are important for

researchers and practitioners to consider. In addition to theories, per se, there are also concepts of theoretical and operational importance that are particularly relevant for health message and audience segmentation. The concepts on which I think we need to focus are involvement with the topic, with the message, and with the audience; health literacy; locus of control; self-monitoring; sensation seeking; and reactance proneness. And the notion of reactance also comes up in regard to a theory that I will mention shortly. As I share these ideas with you, I'm hoping that you will think about how you can incorporate theoretical notions in the work that you do. In addition to theories, I will discuss the concepts I just mentioned. I would like to share with you a quote from Jill Yamasaki (2021, p. 42): "Given the nature of interpretive/critical approaches to health communication, it is not always possible, practical, or desirable to consider theory as distinct from methodology and representation."

I think we should first focus our discussion on some interpersonal dimensions, including dyads and groups. That is generally the first issue of concern: interpersonal communication health theories. Part of this should include a focus on families interacting in the healthcare context. Additional important conceptualizations are theoretical frameworks of provider-patient interaction. Three theories are particularly important to interpersonal health: communication accommodation theory, communication privacy management theory, and the theory of negotiated morality. Again, I'm hoping that you're thinking about this in terms of how you can take these theories and incorporate them in your research. As we assess families interacting in the health care context, the four important theories come to mind: the Double ABCX model of family stress and coping, Olson's circumplex model of marital and family systems, inconsistent nurturing as control, and affection exchange theory. Theoretical framing of provider-patient interaction has many applications beyond health but has really important applications to health communication. One should draw attention to proto-theory in studies of provider-patient communication, the ideal of patient-centered communication, the heritage of antiquity, relational models, and social and public conduct.

Various perspectives on influence processes are also relevant to health communication. We know that much of communication and particularly health communication involves influence processes. So,

we must consider information-processing and cognitive theories, theories of affective impact, theories of behavior, and theories of message effect. There are also a number of theories about message effects that must be considered because they're all relevant to health communication: agenda setting, cultivation theory, narrative engagement framework, framing theory, inoculation theory, uses and gratification theory, and media complementarity theory.

In terms of organization and society, we should look at social psychological theories, theories of public relations, theories of uncertainty, and cultural theories. Finally, we must consider digital media technology. A consideration of digital media includes two basic foci: the cue route and the action route, with a number of theories within those. We must also think about perspectives for the future. These include needs for multi-level, system-oriented thinking; longitudinal theorizing; translational implementation and dissemination; and integration with regulatory science. And, theorize about misinformation. We study it, but we don't theorize about it much; wouldn't that be fun? How to do so? I will look forward to that.

LC: Which sub-area of health communication do you think encounters most difficulties in theorization?

TT: I think provider-patient communication in many ways is one of the more difficult to frame theoretically. Much of the research on provider-patient interaction has not historically been theoretically framed. Peter Schulz and Shaohai Jiang share with us some kinds of proto-theory in studies of provider-patient communication; those are concepts and studies that can help us make sense of the theories in the provider-patient contexts.

LC: Research ethics is a major concern in communication research. Ethical issues are particularly relevant in health communication because research in this field could have direct impacts on individual and community health. From your perspective, what are the most critical ethical issues in health communication?

TT: What I would like to leave in your consciousness is the critical influence of ethics in any line of research. When we are focusing on communication related to health issues, concerns are inherently raised

about ethical issues. In this regard we need to focus on ethical concepts in terms of theoretical approaches and guiding precepts, including beneficence, respect for autonomy, equity, utility, and truthfulness. The ethical issues are especially relevant to clinical and organization contexts, such as truth-telling, diagnostic uncertainty, sensitive topics, whistleblowing, and boundary crossing. In addition, ethical issues are particularly relevant to recently raised digital and social media contexts, including equity concerns, autonomy and privacy concerns, healthcare quality, and potential harm. And then I think campaigns are where we first studied ethics in health communication, in the health communication and social marketing campaigns. The ethical topics in campaigns include segmentation, labeling, stigmatization, risk/fear/provocation, appeals to responsibility, positive social value, and depriving.

LC: Research on health communication has flourished in Asia in recent years. As a scholar who has conducted health communication research in various Asian cultural contexts, could you share with us how you think about the theorization of health communication in Asia?

MD: In terms of theorizing health communication in Asia, I have put in the term—transformation—as the basis for thinking through this because I'm really interested in the question of habitus meaning, in terms of how we take our location and specificity in Asia seriously, and ask the question: what does it mean to theorize from Asia, to theorize in Asia, and to theorize about contexts, drawing on empirical observations that are emergent from within Asia? So, the way I will position my answer is to begin by what I see as hegemonic health communication theory and the trappings of health communication theorizing within Asia, or within the broader structures of hegemonic communication theories. I will articulate how I see these as colonizing structures situated within metric games of Asian universities, which actually prevent us from theorizing in ways that are meaningful to Asian contexts. So, within that sense, I would like to address more on the institutional barriers, and the ways in which I see metrics themselves as colonizing processes that prevent serious theorizing. And then I would like to explore what it means to build Asian imaginaries as the basis for theorizing health and communication.

LC: You mentioned that colonizing structures exist in the theorization of health communication in Asia. How do we understand the concept of hegemonic health communication theories?

MD: To answer this question, think through this question of who defines a theory. If you historically look at the landscape of theorizing, much of the theorizing, however, in fact, over 90% of the theorizing in communication, and certainly theorizing in health communication happens in the Global North. So, you can see where I'm going with this, that in terms of the spectrum of theory and theorizing, we see a fundamental inequality in terms of who does the theorizing, and who gets theorized upon and what bodies get theorized on.

In articulating this inequality, I draw upon my recent pieces of work *Theorizing from the Global South: Dismantling, Resisting, and Transforming Communication Theory*. We argued that theorizing from our habitus in the South is often a replication of Western, predominantly white, theories, so that the nature of theory building work becomes one of testing theories that have been constituted within the logics of the North without really interrogating the fundamental principles and logics that constitute these theories. In another piece of my work *Whiteness, Internationalization, and Erasure: Decolonizing Futures from the Global South*, I argued that much of the current conversation on decolonization simply takes white US-centric frameworks and reproduces them without really asking to what extent the frameworks fit within the contexts, and moreover, continuing the colonizing processes, so that the fundamental inequities in theorizing continue to be reproduced.

When it comes to hegemonic health communication, I have argued that this particular logic of theorizing is an embodiment of whiteness, because it depicts the fundamental assumptions of white cultural values, in terms of what human beings are and how human beings work. And within that, the US-centric white cultural values tied in with logics of capital hold sway over how we conceptualize health as an individualized commodity, without interrogating notions of relationality, without foregrounding notions of community, or without exploring relationships with the ecosystems and the broader structural contexts within which people inhabit their lives. This then has to be situated in the backdrop of the capitalist onslaught on Asia, and particularly the neoliberal onslaught on Asia since the 1980s, and then

that has accelerated since the 1990s, which has meant that this kind of individualization that you see in health communication theorizing is replicated in the capitalist onslaught that has foregrounded logics of profit extraction, labor exploitation, and market fundamentalism that threaten human health and livelihoods. Within this kind of theorizing, then you see how capital replicates itself, mirrored by the architecture of a US-centric health communication frameworks embodied in whiteness. Health communication in the Asian university becomes a site of replica of this whiteness, carried out at the outposts of global neoliberal capital.

LC: Could you elaborate more on your argument about Asian universities being the sites of replica of whiteness? Also, you talked about the "metric games" in Asian universities, which include the emphasis on journal impact factors, rankings, and quantity of journal publications. What is the role of these metric games in theorizing health communication in Asia?

MD: The desire for whiteness pretty much plays out in Asian universities, in their chasing of metrics, in their articulation of what is knowledge and what counts as knowledge. The metric game is the ultimate form of neocolonialism, one that perpetuates the hegemony of US-based journals and knowledge claims. Because these journals publish largely US-based scholarship mired in whiteness, scholars from Asia compete to uncritically copy US-based models and cite US-based white scholars in order to get into the U.S. journals. In other words, logics of whiteness are adapted into Asian contexts as replicas where we are promoted and rewarded for reproducing and circulating the constructs that are embedded in whiteness. This metric game ends up circulating the racist ideology of whiteness, at the same time, devaluing cultural contexts and articulations that are tied to people's ways of living and their everyday struggles across Asia. Culture is often put in as an afterthought then, or as a variable that circulates these hegemonic essentialisms, such as individualism-collectivism, that is often thrown in as a construct, while at the same time, erasing the richness of contexts of cultures. Cultural sensitivity becomes a way for reproducing the hegemonic logics and adjusting to culture as a variable, while at the same time, undermining the communal,

the connected relational ways of being. This entire structure then is facilitated by rankings regimes driven by largely white rankings multinationals that reify the hegemony of whiteness. Having mentored Asian scholars while heading a Department of Communication in Singapore, I struggled with the imperatives of a rankings-driven infrastructure that held up whiteness. It became clear to me that any authentic attempt to create infrastructures for doing Asian health communication scholarship has to first dismantle the rankings regime. We must recognize that the whiteness of the metric game prevents any serious Asian theorizing from taking place. Scholars in major institutions in Asia are rewarded for publishing in US-centric journals, which continue to retain, reward, and circulate the US-centric logics. When I look at the journal I edit, when I think through that, all the way from the fundamental logics of what it takes to get published in that journal, to what even is considered as theory going back to my initial point about theory, ends up perpetuating the whiteness unless we actively intervene to dismantle it. So, these metric games actually reproduce and reify those systems of whiteness by further extending the reach of whiteness into Asia, such that at the end of the process, what you ended up getting, as we internationalize, and that was the argument I was making that piece on internationalization, is a reworking and reproduction of the US hegemony of theorizing.

LC: From your perspective, Asian universities' endeavors to achieve internalization are the mere realization of being Americanized, or, more critically, being colonized by US-centric whiteness. So, what does it mean to build "Asian imaginaries" as the basis for theorizing health communication?

MD: For me, Asian imaginaries for theorizing are about imaginaries for anti-colonial futures. These imaginaries are rooted in the anti-colonial struggles of the 1950s that shaped many Asian imaginations within the context of newly emerging post-colonial states. So, we need to think about how we build southern capacities to imagine health and well-being from within the multiple diverse registers across Asia. Asia as southern spaces to imagine based on ideas of community sovereignty, relational ties, familial frames, communal good and public good, situate health as a public resource. How do we build southern theory

by facilitating southern knowledge flows? How do we dismantle the logics of neoliberal capital and underlying hegemony of extreme capitalism that reproduces inequalities through the shallow pursuit of individualism? How do we build generative futures for health that are anti-capitalist? Note how to theorize from the Global South is to be explicitly anti-colonial and anti-capitalist. Here is an example about community-driven health imagined from the Global South. There are ample examples of community-led food gardens and seed banks, where the community defines health as a fundamental form of community sovereignty over food, where community owns its access to healthy food. Here health as food takes the form of community ownership of agriculture for sustenance, resisting the corporate colonization of agriculture. Sustainable practices of agriculture through community ownership and assertion of sovereignty offers a transformative model of health and well-being. Along these lines, we need to keep thinking through how we can fundamentally think of Asian health communication as an anti-colonial way of looking at and organizing health communication.

LC: You just mentioned that the development of health communication in Asia should adopt an anti-colonial approach; that is, Asian scholars should think more about introducing new theoretical concepts relevant and unique to the Asian cultural contexts and reduce replication of and reliance on concepts derived from US-centric frameworks that might not fit the local contexts. From this perspective, could you elaborate more on the challenges of studying health communication in Asia?

MD: For this question, my argument is that the ongoing challenges of health in Asia, in the midst of onslaught of capital and neoliberal extremism, in some ways, is the necessity to foreground structures. Certainly, COVID-19 made this visible in so many powerful ways. Asian urbanization is somewhat aimed to look beautiful and sophisticated to the Western eye, while what actually underlies that is a huge underbelly of deprivation, of dispossession, where actually we find dramatic health inequalities. So, within this context, the culture-centered approach talks about how we need to look at culture as constitutive of context to foreground the agentic capacity of communities of people to articulate

solutions that fundamentally challenge the structures that threaten human health and well-being. Note here that this means we move away from the kind of Asian essentialisms such as you see in the "Asian values" conversations that use the language of culture to sustain elite power and control. For the inequalities in health to be addressed, we need to conceptualize the ways in which infrastructures for community voices can be built so communities can aspire to achieve health and well-being.

LC: Indeed, we saw what happened in India in the second wave of COVID-19. Poor people had no access to medical resources, and their needs and voices were unheard. The allocation of medical resources was largely based on the elites' ways of thinking without the inclusion of local voices. The culture-centered approach you mentioned is to explore the interplay of three factors—structure, culture, and agency in community health. On the other hand, challenges and opportunities may co-exist. What do you think are the opportunities of theorizing health communication in Asian contexts?

MD: I see the work of theorizing health communication as the work of transforming structures, so that we can create equality in the distribution of fundamental structural resources, all the way from income and wealth, to opportunities of life, information, evidence, knowledge, which are tied to the project of building communicative equality, in terms of ownership of information resources, resources for making knowledge claims and creating evidence, and resources for building representation, decision making, and voice. This is all structured within the struggles for building infrastructures of listening, so that communities we work with, whose health we seek to work with, to improve, actually have registers for their voices to be heard, in ways that are meaningful, so that their health and well-being can be improved. Health communication takes the form of community-led grassroots organizing so that we can actually sustain these efforts of health and well-being. The work of health communication takes the form of creating communication infrastructures, where communities can build networks of solidarity in their struggles for better health and well-being. Also, they can have communicative sovereignty,

where they can actually own or feel sense of ownership of those communicative infrastructures on which they can articulate their voices, where they can connect across spaces and build multiple nodes for articulating their voices.

LC: Health communication research often involves drawing knowledge from disciplines such as sociology, psychology, public health, and statistics. Based on your research experiences, could you share with us your observations of challenges to and noteworthy features of transdisciplinary collaboration in health communication?

MD: I think it's a great question. I think the challenge there is even articulating what health communication brings to that conversation. And I suppose, you know, for me, the point is working in a cross-disciplinary context, when I work with architects, or with agricultural engineers, and I think the challenge there is to begin with what really is the problem, and then starting from the problem, to think about what communication brings to it. Almost always, there is a communicative dimension of the problem that needs exploring. And for me, this dialogic spirit, an openness to having that dialogue and to really understanding as much from others about how they see the problem as it is about bringing our own understandings to those conversations, is what underlies transdisciplinary collaborations. In my own work that brings a justice-based approach to health communication, transdisciplinary collaborations extend beyond academia to relationships with activists, advocates, community researchers and community organizers. That to address health inequalities we must transform unequal structures shapes the nature of my own transdisciplinary work.

LC: In recent years, many young scholars have joined the field of health communication and are devoted to health-related research. Could you provide some suggestions for them?

TT: I think one of the things that is really important is the notion of reaching out and networking. That's such a Western word, but so important for young Asian scholars. One of the things that I've been struck by with the particularly the young scholars from China with whom I've had contact, is the relative lack of mentoring that they get from the senior

scholars, compared to what I would expect. I have had a number of young Asian scholars reach out to me because they're not getting much mentoring from the more established scholars. So, I would encourage them to reach out across networks and across disciplines and fields, and areas of study. And try to overcome the lack of mentoring that a number of young Asian scholars seem to experience.

MD: I love this idea of reaching out that Teri articulated. The first thing I want to say is "believe in yourself." Believing in yourself is believing in your context, having enough faith to know that the context that you come from has things to offer to teach. Don't let the US-based disciplinary hegemony dictate what you study and how you study. You don't have to keep replicating the constructs of whiteness developed through empirical analyses of largely white samples in the U.S. in order to actually build theory and find a way for yourself to survive in academia. Pay close attention empirically to the context within which you are embedded, the lived experiences of health within the context, and the meanings of health that serve as anchors for how individuals, families, and communities negotiate health. Don't blindly replicate reductionist constructs such as individualism—collectivism that emerge from a largely decontextualized white lens imposed on cultures to compare them. That's the first thing I would say. A second thing along those lines is: pay close attention to the materiality of everyday life. Build theory by taking seriously the everyday empiricism emergent from the ground. What this means is that don't bring the assumptions of a particular theory that has been imposed on you by a colonizing structure and then ask the question: how do I replicate it to address this problem? Instead, really attend empirically to what you see within that context and respect the context. Let the empiricism emerge from within the context and guide you in doing and developing your theory. How then do we generalize, compare, and synthesize from within the contexts of Asia takes the concept of Asia, replete with its diversities and fragmentations, seriously? For instance, the notion of healthcare as rooted in socialist values of universal distribution across multiple Asian economies foregrounds a framework of universal access, rooted in the collective. It is clear that we are at a moment of disciplinary history in health communication where we must urgently decolonize the discipline. And decolonization is

fundamentally about undoing the concepts and the methods that have been circulated within the structures of whiteness, and instead starting from nodes located in Asia. Of course, for all of this to happen, the work at hand is to actively decolonize the Asian university.

Selected Works by Teri L. Thompson and Mohan J. Dutta

Please refer to the end of the Chinese version of the dialogue for Teri L. Thompson's and Mohan J. Dutta's selected works.