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Mutuality, mobilization, and messaging for health promotion: Toward collective cultural change

1. Toward collective cultural change

Ill health is a major social problem and source of social inequality in the United States. Although the US spends more on health care than other wealthy countries, it falls far behind on most measures of health outcomes and indicators of heath care quality, access, efficiency, and equity (Davis et al., 2010). As an illustration, mortality rates for white males in the United States have climbed or remained stable between 1990 and 2013, yet declined for the same group in other western industrialized societies (Case and Deaton, 2015). We have plenty of evidence on the impact of discrimination and inequality on health outcomes (Williams et al., 2003; Schnittker and McLeod, 2005; Lynch et al., 2004). The cumulative stress associated with marginalized social conditions contributes to a greater allostatic load and a steeper health gradient (McEwen and Seeman, 1999; McEwen, 2005).

Improving health outcomes requires ameliorating the social conditions that foster poor health. Better understanding the conditions that may counterbalance their impact is crucial and urgent. Health care accounts for only a small fraction of what impacts health (Mokdad et al., 2004). Thus, understanding social challenges to health and wellbeing requires broadening the conversation to include experts outside of the health field to capture the cultural processes at work (Hall and Lamont, 2009). This special issue represents one step towards this broader goal.

Societies that are more socially inclusive have demonstrably better health outcomes. Indeed, experts on social capital have shown that a strong sense of belonging, more social cohesion, and trust are positively correlated with better health (Berkman, 2000; Kawachi and Berkman, 2000). Thus, it is imperative to develop a better understanding of how to promote these objectives. This is the objective of our special issue: contributors consider how to promote a greater sense of mutuality through mobilization and messaging. We do so in conversation with the Culture of Health (COH) strategic framework that the Robert Wood Johnson Foundation (RWJF) launched in 2014, whose goal is better health across the social gradient. Civic engagement, social cohesion and solidarity ("we are all in this together") are at the center of this vision.

The health research community — social scientists as well as public health experts — knows much about how social relations support better health outcomes. The distinctive contribution of this issue is to mobilize the analytical tools of cultural and political sociology to provide insight into the social and cultural factors that influence the level of social cohesion and societal solidarity. This complements other efforts to consider the impact of culture on health (Woolf and Aron, 2013). For the Organization for Economic Cooperation and Development (OECD, 2011, p. 17), a cohesive society "works towards the well-being of all its members, fights exclusion and marginalization, creates a sense of belonging, promotes trust, and offers its members the opportunity of upward mobility" (also Jenson, 2010). We adopt this definition but complement it with a focus on solidarity, or mutual support, as demonstrated in the promotion of greater equality, including through redistribution and destigmatization (Lamont et al., 2016; Banting and Kymlicka, 2016). Given these definitions, we organized the issue around three themes: *mutuality* ("we are all in this together"); *mobilization* (civic engagement and participation), and *messaging* (communication). Contributions bring culturally oriented social science literature to a consideration of mechanisms and factors influencing these dimensions.

2. Thinking about social cohesion and solidarity

The literature on social cohesion ranges from studies of norms (how do individuals come to adopt pro-social behavior?), to research on how collective identity fosters a sense of community and solidarity, which can affect (and is influenced by) sources of social support, the strength of social networks, as well as collective efficacy (how much individuals feel that they can affect their environment and control the behavior of those around them). Also of relevance are studies of cultural change (from less patrimonial to more meritocratic relationships; or from more individualist/instrumental to more collectivist/expressive orientations) and case studies of civic involvements, through volunteerism and participation in various types of organizations (whether collectively oriented — civic, religious, political, philanthropic, or ethno-racial — or dedicated to the pursuit of individual interests — via expressive culture, sports, etc.) While much of this literature examines moderators, mediators, or factors that have a direct impact on health, we are concerned with understanding cultural and social processes that are often multi-leveled and present feedback effects between broad cultural frames, civic mobilization, and solidarity and social cohesion.

A compendium of our knowledge about social cohesion can be found in the large tradition of community studies that sociologists have produced. To take one example, Hervé Varenne (1977)'s *Americans Together*, explored ethnographically how Midwesterners create community through intentional individual involvement in the context of a small town, by attending church, volunteering, and getting civically engaged. They view individualism as natural and understand community as the result of individual actions. They also regard groups as enabling the attainment of individual

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goals. While their vision of community remains relatively limited, these individuals experience cohesion through their shared cultural frameworks. Revisiting similar themes, *Habits of the Heart* (Bellah et al., 1985) revealed how utilitarian and expressive individualism coexist as alternative impulses among middle class Americans to create a society where community remains elusive.

Both studies show how individuals draw on scripts in their environment to learn how to "do" limited forms of "collective life" together, particularly through somewhat privatized "lifestyle enclaves." These social scientists are problematizing community making as a process, i.e., specifically by considering the kinds of cultural supports and cultural repertoires that create conditions for solidarity or the lack thereof (see also Lichterman and Eliasoph, 2014; on civic styles). Along the same lines, in *Villa Victoria*, Small (2004) showed how in a particular Latino community in Boston, the investment of individuals in their immediate neighborhood is tied to how they connect the latter with the history of their ethnic group and collective identity — how they take ownership of the space through their self-concept. For their part, Bloemraad and Wright (2014) have shown that societies adopting multicultural policies signal to immigrants their value to their host society, which results in their greater cognitive investment and political participation in this society. Thus, authors identify concrete factors that enable the diffusion of cultural repertoires supporting social cohesion or broaden definitions of cultural membership (Hall and Lamont, 2013). Of course, there are also contradictory forces at work, which individuals have to contend with. For instance, as illustrated by Mary Pattillo's (2013) *Black Picket Fences* — a study of an African-American neighborhood in Chicago — interclass relationships can put strains on solidarity, as individuals have to stay clear from the "hands that pull you down" if they want to stay the course and pursue their own dream of upward mobility. Such enabling and constraining dimensions and their potential impact on the development of solidarity are the object of our special issue.

We focus on a range of cultural and institutional factors likely to mediate whether and how individuals (a) experience social cohesion, (b) are preoccupied by the welfare or subjective wellbeing of their co-citizens, (c) promote a broad definition of cultural membership which extends to stigmatized and low status groups (Hall and Lamont, 2009, 2013). We are particularly focused on whether people are concerned with the relational quality of their society, including balkanization and inclusion. This may manifest itself in variations in the degree of preoccupation for racism, xenophobia, poverty, and inequality, which are inversely correlated with social cohesion and solidarity. We are particularly concerned with identifying how the promotion of a culture of solidarity occurs in situ, in specific instance and through specific practices.

This special issue consists of ten articles. The first article by Plough and Trujillo details the RWJF's Culture of Health action framework, which is an important point of reference for contemporary discussions of health promotion. The remaining articles address the issue of social cohesion through the lens of our three broad analytic terms that are foundational for any project that aspires to creating social change: *mutuality, mobilization and messaging*.

3. Understanding mutuality, mobilization and messaging

With the word "mutuality," we capture the centrality of solidarity and cohesion for counteracting the pathways that reinforce the health gradient, and more generally for collective cultural change. With "mobilization" we point specifically at the ways in which collective action promotes social transformation that directly or indirectly affects health or health-related behaviors. With "messaging," we focus on the processes by which the values of wellbeing, solidarity, and recognition, can be more broadly diffused and embraced.

Mutuality is the recognition of reciprocity, of having a sense of moral obligation to value and support the wellbeing of others. A feeling of mutuality is essential to social cohesion. It is typically based on or sustained by a shared identity — or a shared definition of "us" and "them" (as family members, co-ethnic, co-citizens, or simply universal human beings). Identity is often understood as an individual or social psychological phenomenon (Burke and Stets, 2009) and as having both an internal dimension – or self-identification: (who do I think I am?) — as well as an external dimension — or group categorization: (who do others think I am?) (Jenkins, 1996). It is moral as well as emotional and ontological, and varies in salience over time and space (Stryker, 1980; Taylor, 1994).

Cultural and political sociologists have given ample consideration to identity as a collective phenomenon that is based on shared narratives (Somers, 1994) that play an important role in social change. In the political sphere "who are we?" (Berezin, 1997, 2010; Lichterman and Elisaoph, 2014) takes precedence over "who am I?" Legal institutions (e.g., the state) govern many of our categorical identities. Moreover, the relationship between collective identity and the mere sharing of a categorical/legal identity ("my fellow American citizens), is highly variable. Health promotion requires that individuals cultivate a sense of collective identity and solidarity around health behaviors without the obvious benefit of legal institutions to enforce that feeling of belonging (were such enforcement even possible). While many have studied the impact of welfare state regimes on health through redistribution (via institutions and politics; e.g., Beckfield et al., 2015; Chung and Muntaner, 2007), few have considered the cultural dimension of this relationship.

Tensions around mutuality (or reciprocal moral obligations) are where social inclusion and exclusion, or group boundaries often become visible (Lamont and Molnár, 2002) and where definitions of justice and solidarity diverge (Elster, 1992). While psychologists study this process as interpersonal and intra-psychological dynamics (e.g., Tajfel and Turner, 1986), sociologists have focused on intersubjective (including moral) meaning-making and consider how they are shaped by groupness (e.g., Lamont et al., 2016). This literature illuminates processes of formation of group solidarity through shared definitions of cultural membership, based on shared views on similarities and differences anchored in cultural memory, shared myths, and available cultural messages (such as political messaging) (Swidler, 1986).

Social movement scholars address the issue of *mobilization* — that is, the capacity of leaders to organize groups around grievances that are of collective concern. Grievances range from "big" "national" issues such as civil rights to more local issues such as demands for housing in a specific geographic area. In the seventies and eighties, social movement scholarship focused on organizational capacity and political opportunities (McAdam et al., 2001). A post-80s generation of social movement scholars began to identify frames (Benford and Snow, 2000) and culture as vital components of mobilization (Polletta and Jasper, 2001), whether they focused on discourse (Koopmans and Statham, 2010), meaning (Skrentny, 2006) and even emotions (Bail, 2012). No matter the modality of communication, what this literature shares is an emphasis on the commonalities that bring groups together in pursuit of common goals that are as often normative as they are material (Lichterman and Eliasoph, 2014). Social movement theory provides templates for action around innovative health practices at the local level, for instance by mobilizing residents for improving their neighborhood infrastructure.

But mobilization cannot exclude *messaging*. From the 1920s when Walter Lippmann (1922) first identified the importance of public opinion to politics, activists of all types have recognized that messaging, the capacity to communicate and persuade, is a

core component of promoting any public agenda. Not all messages are created equal. In order for a message to have political value, the audience must grasp its meaning quickly. President Obama's campaign slogans from 2008 had just this quality. “Hope and Change” and “Yes, We Can,” spoke quickly to a large audience. Rhetorical force, retrievability and resonance are among the key qualities that any message aimed at moving public opinion must have. Together with institutional retention (institutionalization) and resolution (in directing action), these qualities ensure that some messages get traction and others do not (Schudson, 1989). Rhetorical force is what makes something memorable or powerful; retrievability points to accessibility, while resonance means that your audience actually agrees with you — that what you say “connects” on some level given background assumptions. Public messages about health behaviors are likely to be more effective if they have qualities such as “frame resonance.” “Moreover, some narratives are more efficient or persuasive if they use emotions as well as stereotypes (Polletta et al., 2011).

Below we describe how each of the articles included in this special issue speaks to the notions of mutuality, mobilization, and messaging as they relate to health promotion. The first paper, coauthored by **Plough and Trujillo**, spells out the Robert Wood Johnson's Foundation's vision for a Culture of Health. This serves as a background against which the other articles define their focus.

3.1. Mutuality

These papers show how cultural repertoires, institutions, and public knowledge support or inhibit mutuality. **Bloemraad and Terriquez** focus on the role of community-based organizations (CBO) in fostering mutuality by studying thirteen low-income, predominantly immigrant communities in Northern California. They show how these CBOs 1) empower individuals by reinforcing civic capacity and personal efficacy; 2) foster solidarity by building networks, social identities, and a commitment to collective well-being; and 3) mobilize people to have a voice in health-related policies. For their part, **Clair, Daniel and Lamont** compare the destigmatization process of three groups in the United States: people living with HIV/AIDS, African Americans, and people labeled as obese. Their article complements the psychological literature on stigma reduction by examining socio-cultural processes at work. Drawing on a detailed analysis of the secondary literature, these authors argue that the conditions that account for the uneven destigmatization of these groups over recent decades include the credibility of new constructions, the interaction between new constructions and existing cultural repertoires, the status and visibility of actors carrying them, the conclusiveness of expert knowledge about stigmatized groups, and the perceived linked fate of the stigmatized and dominant groups. Their consideration of destigmatization concerns specifically the improvement of public attitudes (public stigma) and increased inclusionary organizational, governmental, and societal policies and practices (structural stigma). **Berezin and Eads** approach mutuality by studying the phenomenon of childhood vaccination resistance. They draw on fifty-seven years of newspaper accounts on vaccines to identify variations in the public narratives and perception of risk and disease related to vaccines. They find that while risk has always been a feature of vaccine narratives, the perception that the risks of vaccines out-weigh the benefits has grown. They then use school-level data from New York and California to explore how these public narratives shape a geography of vaccination rates. Differences in the socioeconomic status of the geographic locales where vaccination rates are low suggest a contrast between “imagining risk,” (the prerogative of the affluent), and “being at risk,” (the fate of the poor.) Authors argue that vaccinated communities are natural domains of reciprocity: To not vaccinate is to opt out of the community and to place your fellow members at risk of disease. Thus, vaccination resistance speaks directly to a Culture of Health as it poses questions about the collective perception of risk and its relation to social inequality and solidarity.

3.2. Mobilization

Health promotion initiatives such as those of the RWJF can only be as effective as the extent to which they spark a social movement for health. The papers in this section distill lessons learned about mobilization from previous social movements and examine the factors that facilitate mobilization.

Epstein uses secondary literature to examine the mobilization of disease-specific patient advocacy groups. His purpose is to determine lessons from these groups and their strategies that might appeal to larger scale mobilization efforts aimed at a diverse set of constituencies. He argues that when “disease constituencies” mobilize, they produce ripple or “spillover” effects within diverse disease communities. Drawing upon the literature on health and social movements, he notes that there is a considerable amount of overlap and diffusion among disease activists, and he explores the “linkage mechanisms” which make this interpenetration possible. These linking mechanisms include: “spillover,” e.g., AIDS activists borrowing conceptual frames from feminist movements; “coalition building,” e.g., building organizations such as the *National Organization of Rare Diseases*; and “frame alignment,” e.g., borrowing claims from kindred disease groups, as was the case for AIDs activists who included hepatitis C in their rhetorical repertoire.

Dasgupta and Lichterman investigate community health mobilization and, more specifically, how seemingly disconnected social issues can be effectively combined, using housing advocates in South Los Angeles as a case study. The housing activists they studied combine a plea to save a local hospital with their demands for fair housing. They show how a flexible discursive field enables activists to combine claims about health and housing — seemingly separate problems with separate constituencies — in terms of a master category of the field. Inside the field, activists articulated both issues as matters of social justice, but did so selectively, in ways that complemented their shared sense of social identity, or “style.” Different styles produce different trade-offs. A “community of interest” can promote a narrow issue to a wide constituency, while a “community of identity,” such as the advocacy effort studied here, could promote multiple issues such as housing and health, but only to a geographically and ethnically specific locale.

For his part, **Vargas** examines the role of cultural competency in mobilizing low-income minority groups to sign up for health insurance under the Affordable Care Act (ACA). He conducted a series of interview with “Health care navigators:” people hired by the federal government to get low-income people to sign up for ACA. He discovered that those who simply provided information about rights or insisted that individuals sign up were not particularly effective. In contrast, navigators who established personal ties either through ethnicity or empathy for the difficulties involved were far more effective at getting people to sign up. This is in part because the disempowered target population experience considerable distrust toward both the government and the medical professions, from whom they are culturally distant. These findings suggest the value of a bottom-up approach to improving health-related behavior: It is important to reach out to potential beneficiaries “where they are” and frame action strategy in terms that are resonant to them.

3.3. Messaging

A key component of health promotion is the shifting of the

messages associated with health. Messaging can act as an effective tool to foster mutuality and catalyze mobilization. The papers in this section explore the impact of messaging and its role in previous movements. **Frederick, Saguy, and Gruys** examine how health messages, specifically those about weight, can impact attitudes about health. The authors conducted three experiments to examine the effect of culture frames on attitudes about obesity. They find that exposure to different frames lead to a change in perception of health risks, and suggest that nevertheless, dominant (negative) portrayal of obesity are undermining solidarity toward the overweight and the obese. They conclude that exposure to fat rights viewpoints could be part of a culture of health strategy as it fosters empathy toward these stigmatized groups. **Bail** uses Facebook data regarding organ advocacy groups to develop a theory of "cultural carrying capacity." He argues that broad cultural messages are effective at producing a large but disparate following whereas targeted cultural messages are effective at producing a cohesive but small following. This author recommends that effective health communication focus on a few well-defined issues that can diffuse widely through social media. For their part, **Schudson and Baykurt** examine the decline in cigarette smoking as both a by-product of health education around the dangers of tobacco and a set of social status practices. They begin with the 1964 Surgeon General's report that identified the link between cigarette smoking and lung cancer. They trace the public narratives around the toxic effect of smoking through government reports and citizen mobilization. They show that cigarette smoking went from being constructed as an individual to a collective toxin when the dangers of second-hand smoke became a common frame of the anti-smoking discourse and scientific investigation. With that transformation, smokers were viewed as not only endangering their own health but also that of others. Smoking became a socially stigmatized practice that could be mapped along class lines. Schudson and Baykurt's article suggests that health messaging needs to be sensitive to the nuances of perception along class lines.

4. Conclusion: a culture of health

This special issue aims to encourage cross-pollination across social science communities in order to strengthen our understanding of the cultural dynamics supporting a wide range of pro-health practices. Our contributors aim to engage the tools of cultural and political sociology to inform collective thinking about how to promote better health outcomes through social cohesion and solidarity. Together, they touch upon a fairly specific set of processes that contribute to the promotion of mutuality, messaging and mobilization. Yet, they also suggest several research agendas moving forward. These may feed into the promotion of a culture of health, along the lines suggested by the Robert Wood Johnson Foundation.

Articles on *mutuality* focus on cultural and institutional factors that enable and constrain mutuality — community based organization, the role of actors and expert knowledge and the impact of public knowledge. Clair, Daniel and Lamont point to the role of cultural intermediaries and additional factors that contribute to destigmatization. Berezin and Eads highlight resistance to mutuality through their study of vaccine resistance where the affluent opt out to the detriment of the excluded. Future research should engage in a systematic examination of cultural dynamics influencing processes that inform mutuality as well as how those processes interact with distribution of resources to affect social inclusion and cohesion. This suggests the importance of developing a sociological understanding of recognition and distribution as complementary dimensions of social cohesion and inequality (Fraser and Honneth, 2003). The meaning associated with other stigmatized groups, such as the poor and Muslims vary considerably across national contexts (Mijs et al., 2016) and are subject to the cultural influence of far right political parties as well as other producers of social frames (Berezin, 2009). While the literature tends to focus on stigmatization and discrimination, much more attention should be paid to how social inclusion is produced through multi-level dynamics across social settings.

The papers on *messaging* contribute directly to this agenda by considering which types of frames are most efficient at promoting greater solidarity. Frederick, Saguy and Guys show how fat-right frames may produce more empathy toward the overweight and the obese, while Bail shows that broad, less targeted messages concerning organ donation have more "cultural carrying capacity" and may be more effective at influencing behavior. Schudson and Baykurt demonstrate how anti-smoking messages got traction when second-hand smoke transformed smoking from an individual to a collective harm. At this juncture, it would be fruitful to connect such insights concerning "cultural power" to findings from the growing field of health communication (e.g., Randolph and Viswanath, 2004; Viswanath, 2006) for a better understanding of the diffusion mechanisms of pro-health behaviors.

Papers that concern *mobilization* focus on the deployment of cultural frames and actions that make social movements more effective. The papers by Epstein, Dasgupta and Lichterman, as well as Vargas, alert us to the importance for movements to bundle claims in order to maximize "linkage mechanisms" such as spillover effects. These papers produce findings that resemble those of Schudson and Baykurt as well as Berezin and Eads in that they point to the importance of paying heed to how class group relates to institutions involved in the promotion of health, whether the medical profession or policy makers. More knowledge is needed to identify specific differences in health-related attitudes and practices across ethnic and class groups (Daniel, 2016; Harding et al., 2010; Lamont and Small, 2008). These papers are remarkable in that while they have a primary analytic focus they also cross analytic boundaries. Berezin and Eads can be as much about messaging as Schudson and Baykurt and vice versa. If they were not influences by the ties of mutuality, Vargas' community organizers would not have been successful in their mobilization. These cross-cutting categorizations point to the richness and complexity of cultural analysis as we move a COH forward.

Finally, while all the contributions to this special issue focus on the American context, future research should also take on a global perspective to consider not only cross-national differences in social cohesion, but also the transnational diffusion of models of inclusion (e.g., Paschel, 2016). It will also be important to consider whether and how risk and resilience are influenced by different types of narratives (e.g., about hope and social justice) across national contexts (Panter-Brick, 2014). Moreover, new approaches should also promote partnership, not only between social scientists and health experts, but also between foundations and practitioners across the north/south divide.

This special issue aims to promote a lively dialogue between, as well as greater scholarly complementary, among health experts and social scientists concerned with processes such as social cohesion, solidarity, and the transformation of group boundaries. Cross-pollination between research traditions and communities are essential to promote a better understanding of how to influence the social determinants of health and to promote a culture of health. Taking this conversation to the next level would require an expansion into the arena of Global Health. Indeed many of the issues that we discuss in this special issue — vaccination, housing, nutrition — to name a few, are global problems which need to be addressed with sensitivity to local cultures. In short, the promotion of cultures of health is a project without borders.

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