Part III
Research proposal & autoethnography

Stress and resilience: College students during emerging adulthood (research proposal)

Terry Bell, Samual Nathaniel Brown, Thaisan Nguon, Larry Torres, and Dara Yin

This paper was prepared for COMM3300: Methods of Communication: Social Science, taught by Dr. Mu Wu)

Introduction

College education is important and it is necessary for college students to adequately perform their duties. Although all professors have been in the shoes of college students, as time passes, circumstances change, and some events become a blur within the mind. We chose this topic to raise the awareness of professors, students, and administration of the stress that college students endure throughout their journey of education.

Stress is a huge contributor towards bad health. Often, our ability to effectively cope with stress or recognize stress within ourselves is absent. Drugs, suicide, and other unhealthy behaviors can be the result of stress, which makes this topic significant. Education can't be acquired without a clear-headed student, or for that matter, a breathing student. Recognizing the problem is the start of resolving the problem. Through this proposed project, students could be more aware and proactive. Also, professors and administration could be more mindful and help decrease stress levels of college students through empathy.

As college students of Cal State Los Angeles cohort 2, we genuinely understand the detriments of stress through experience and observation. As Cal State LA students, we feel obligated to

highlight stress so that our fellow Golden Eagles can obtain the maximal education.

Emerging Adulthood

Denise Solomon and Jennifer Theiss (2013) state that:

"Our self-concept evolves throughout our lives, but changes we experience are especially striking in the period from adolescence to adulthood (around ages 18 to 25) known as emerging adulthood. During this time of life, people in our society are often less constrained by their families and not yet burdened by the responsibilities of adulthood (Arnett, 2000). This relative freedom allows emerging adults to explore a variety of identities before settling on the relationships, jobs, and worldviews that will define their adulthood. This is also a tumultuous phase of life. One study found that college students who believe that they haven't reached adulthood engage in more risky behavior, like illegal drug use or drunk driving, and experience more depression than students who consider themselves to be adults" (Nelson & Barry, 2005 p. 88).

Stress

Stress has been defined as "a state of anxiety produced when events and responsibilities exceed one's coping abilities" (Seaward, 2018). There are also physiological definitions of stress which in combination with others have informed the psychoneuroimmunological (PNI) approach. PNI, as defined by Pelletier (1988), is the study of the intricate interaction of consciousness (psycho), brain and central nervous system (neuro), and the body's defense against external infection and internal aberrant cell division (immunology). PNI is in the field of holistic medicine which defines stress as the inability to cope with a perceived (real or imagined) threats to one's mental, physical, emotional, and spiritual well-being, which results in a series of

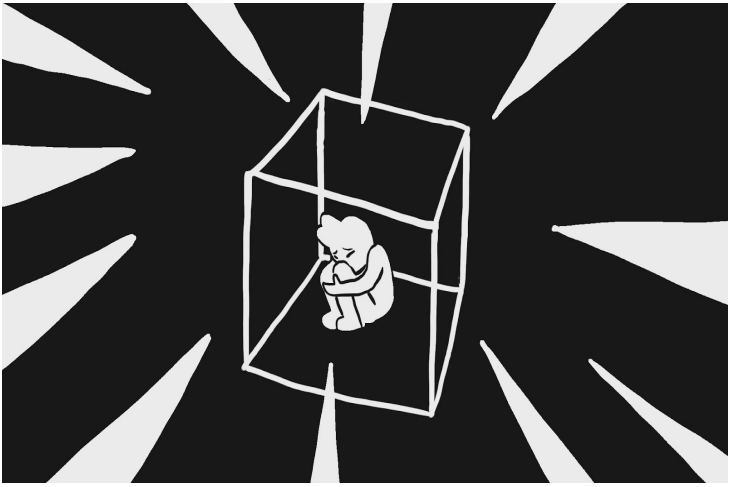
physiological responses and adaptations (Chopra, 2000; Dossey, 2004, as cited in Seaward, 2018).

Stress is a significant factor during college. Seaward (2018) describes the college experience as a transition from a period of dependence to independence. Some of the common stressors that college students encounter include: roommate dynamics, professional pursuits, academic deadlines (exams, paper, and projects), financial aid and school loans, budgeting money, lifestyle behaviors, peer groups and peer pressure, drugs and alcohol, exploring sexuality, friendships, intimate relationships, and starting a professional career path.

Resilience

An informational pamphlet provided by the community *Sustaining Futures* cites that the American Psychological Association defines resilience as adapting well in the face of adversity, trauma, tragedy, threats, or even significant sources of stress. They also cite Bonanno, Westphal, Mancini (2011), who describe resilience as a stable trajectory of healthy functioning after a highly adverse event. Sustaining Futures lists the characteristics of resilience in individuals as follows:

> "Resilient individuals are flexible, accept that adversity happens, have realistic expectations and optimistic thinking, maintain appropriate professional boundaries, use problem focused or emotion focused coping, focus on what is going right, have confidence they can cope, seek social support, and are attentive to people, places, and things that may adversely affect their emotional and physical well-being" (Sustaining Futures 2019).



Literature Review

Melinda J. Ickes, Joanne Brown, Brandy Reeves, and Pierre Martin D. Zephyr (2015) examined the differences between undergraduate and graduate college students in respect to stress and their coping strategies. The aim of the study was to: (1) determine differences in stress levels among undergraduate and graduate college students; (2) determine differences in coping strategies among undergraduate and graduate college students (p.15). The study surveyed a random sample of 1,139 college students at the authors' institution (University of Kentucky) and found that almost 80% of the participants reported moderate levels of stress or higher.

Despite finding no significant difference between undergraduate and graduate college students regarding levels of stress, there were some very interesting discoveries in the realm of coping strategies. The study found that regardless of academic classification, the top three strategies among responding participants were sleep (69.6%), exercise (66.1), and food (56.8%). The study was able to identify five coping strategies (out of a list of twenty) that possessed significant differences between undergraduate and graduate students. These coping strategies were: cigarettes/tobacco (p<

0.001), drugs (p= 0.04), exercise (p= 0.001), pets (p= 0.007), and social support (p= 0.002). The study revealed that, "Undergraduate students were significantly more likely to use cigarettes/tobacco and drugs whereas graduate students were significantly more likely to use exercise, pets, and social support" (p.17) as coping strategies.

Interestingly enough, a CART analysis showed that social support was the most important variable to best explain differences between undergraduate and graduate students. Some 505 students reported using social support as a coping strategy and well over half of them were female. There was a large emphasis in this study on promoting the application of social support as a coping strategy to all students because of its impact on stress levels, well-being, overall life satisfaction and happiness (Chao, 2012; Cohen et al., 1983; Lundberg, McIntire, & Creasmen, 2008).

In order to paint a clearer picture of what undergraduate and graduate students face in terms of stress, the authors could have asked about sources of stress as they surveyed levels of stress from their participants. This could help identify what contributes to the differences in stress levels and which coping strategies would best be suited to address certain situations.

Dr. Ahmad M. Thawabieh and Dr. Lama M. Qaisy (2012) conducted a study at Tafila Technical University to assess the level of stress and its sources in the student body. The study aimed to answer the following questions: (1) What is the level of stress the university students have? (2) What are the factors associated with students' stress? (3) Are there any statistically significant differences […] in the stress level attributed to gender, college, student cumulative average (C.A.), income, and Students Study Level (S.S.L.)? The study found that a moderate level of stress existed and that *social, academic,* and *physical* factors played a role in that stress. Interestingly, the mean stress level score of social factors scored highest followed by academic, and then physical factors. In so many words, Thawabieh and Qaisy (2012)

suggest that mean stress level score for social factors are highest due to—among other things—the traditionally conservative social life that exists in the community and separation issues between students and their respective families (p. 116).

Dana Balsink Kreig (2013) conducted a longitudinal study to compare students' expectations and experiences of college and examined the relationship between violated expectations and stress (p.635). The author predicted that violated expectations would be associated with higher stress (p.637). The study observed expectations and experiences of four domains (Academic, Family, Social, and College) across three timelines.

The first timeline surveyed ninety-nine incoming first year college students during the summer prior to matriculation to measure levels of expectations. The second timeline surveyed the same group of students during the fall semester of the first year to measure levels of experiences (66 students participated). The third timeline surveyed the same group of students during the fall semester of the senior year to measure levels of experiences (36 students participated). The data in the study suggested that, "when the academic and social experiences were worse than expected, students reported an associated increase in stress" (p.641). This is what Kreig (2013) called violated expectations and predicted that more symptoms of stress would be reported when this phenomenon occurred.

However, it is important to note that a violated expectation of the family domain garnered no such increase in levels of stress. In fact, the study suggested that senior students were associated with higher levels of stress when they lacked involvement with their family (e.g. parents). An interpretation of this data can be that with the right manipulation, the family domain can serve as a stress mediator, if not coping strategy.

The four domains are also sources of stress and if the study was able to reveal the duality of the family domain then there should be no restrictions on the other three as researchers of this topic search

for solutions in stress reduction. Sometimes, the best way to change how people react to certain things is to change the meaning of those things.

Misra, Crist, and Burant (2003) conducted a cross-sectional survey of international students at two mid-western universities in the United States. The purpose of their study was to find direct and indirect relationships between life stressors, academic stressors, perceived social support, and reactions to stressors. They further hypothesized that social support would reduce stress.

Stressors and the Stress Process

In the study Misra, Crist, and Burant (2003) conducted a study utilizing 143 interactional students that focused primarily on four constructs: life stress (primary stressor), academic stressor (secondary stressor), perceived social support (stress mediator), and reactions to stress (stress outcomes). They employed Thoits' (1995) specifications of the three major conceptual domains of the stress process: stressors, stress mediators, and stress outcomes. Stressors were defined as environmental, social, or internal demands that caused an individual to adjust their behavior. Misra et al. (2003) also incorporated Pearlin (1989) in defining stressors and their dynamic, identifying three types of stressors: life events, chronic strains, and daily hassles (Misra, Crist, and Burant, 2005).

The interplay of stressors in the stress process is described as one in which one stressor triggers another, in some cases resulting in the development of a cluster of stressors (Thoits, 1995; Pearlin, 1989; as cited in Misra et al., 2003). Misra et al,. (2003) refer to Pearlin (1989) again to emphasize the importance of understanding the full array of stressors in an individual's life, stating how a failure to do so results in a misleading or incomplete inquiry (Misra et al., 2003).

Social Support

Misra et al. (2003) describe social support as a mediator of stress. According to Mallinckrodt and Leong (1992) social support provides a powerful coping resource for students experiencing stressful life changes. They further explain, using Dunkel-Schetter and Bennett (1990) along with Wethington and Kessler (1986), that the perception of social support has a stronger influence on mental health than the actual receipt of social support (Misra et al., 2003). In a sense, social support may not be enough to mediate stress if one does not believe it to be an available resource. The second implication is if a person believes they have social support, but it is not available, then they may still benefit from the outlook alone.

The results of the study supported the hypothesis that life stress would predict academic stressors and reactions to stressors. The outcome agrees with their description of the stress process. The problem with the description is that the categories may overlap. If it is true how stressors may develop into clusters, then it may not be clear as to what the primary and secondary stressors are. Individuals may be subjective in their perceptions and priorities therefore making it difficult to delineate primary and secondary stressors. In some cases, a secondary stressor could occur simultaneously with a primary stressor. In cases where this happens, the placing of a stressor in any category is subjective. It may well be that stressors function more like a cluster than a domino effect-like process.

Stress factors in adolescent community college students

Ahern and Norris (2011) studied the factors that increase and decrease stress in adolescent community college students. They used a self-administered questionnaire for the purpose of determining what factors decrease stress in adolescent college students. Ahern and Norris predicted that women would report a higher level of stress than men, and that resilience and other protective factors would be associated with decreased stress (Ahern, & Norris, 2011).

Citing Miller, Pope, and Steinman (2005), Ahern and Norris discuss how adolescence is considered a turbulent time of developmental stress. Adolescents experience developmental challenges during this life phase which can be complicated by the stresses of attending college (Ahern, & Norris, 2011)

According to Ahern and Norris (2011), the "American College Health Association (ACHA) National College Health Assessment" for 2009 indicated that students (N=80,121) ranked stress as the "highest health impediment" at 33.9%. The data also demonstrated that at least once in the past school year students felt hopeless (62.1%), overwhelmed (983.6% sic), exhausted (91.8%), sad (78.8%), and depressed (43%). Findings also reported how students had seriously considered or attempted suicide (9.0%) (Ahern, & Norris, 2011).

Rutter (1985) describes protective factors as those factors that could modify, ameliorate, or alter a person's response to some environmental hazard that predisposes a maladaptive outcome.

Resilience is considered a protective factor but, in this study, it was considered separately from the other protective factors.

Financial support was considered a significant protective factor in this study. Ahern and Norris (2011) cite Jackson (1999) stating that financial security during college, whether in the form of financial support and/or income, has been associated with less stress by the students. Studies have shown that college students lacking financial support are more likely to be stressed and have psychological problems (Ahern, & Norris, 2011).

The results of this study indicated mean scores for stress and resilience showing that the samples of students were moderately stressed and moderately resilient. The first hypothesis was not supported because males reported a higher level of stress than females. Findings also showed that the protective factors other than resilience had little impact on stress.

It is important to note that participants in this study were predominantly male (59.6%) and Caucasian (77.6%). The sample in this study is not generalizable to the wider population. Whether intended or not, because of the use of a predominantly white male sample, this study is biased. It reflects a longstanding and problematic tendency of marginalizing women and minorities in quantitative research.

Hypothesis

The proposed independent variable would be the students' grade level whether freshman, sophomore, junior, or senior. The dependent variable would be the overall level of stress of the students. The mediating variables would include social support (e.g., family, friends, significant other), and the student's financial stability. We propose there would be a relationship between student's ability to cope with stress and the successful navigation of their academic careers.

Proposed Methods

Sample

An ideal collection of study participants would be a convenient sample and survey of students 18-24 years old who attend California State University, Los Angeles located in Los Angeles, California. Additional criteria for study participation would include **(a)** enrolled and present in the general education class on day of data collection, **(b)** 18-24 years old, **(c)** able to read and write in English, and **(d)** physically able to complete surveys.

Variables

This study would include demographic variables and the study variables of physical health, mental health, emotional well-being, financial support, extracurricular activities, and stress.

List of Proposed Variables

Demographic: Participants would be asked to complete questions related to age, gender, race/ethnicity, grade point average (G.P.A), class (freshman, sophomore, junior, senior), and living situation.

Financial Support: Participants would be asked to indicate whether they received financial support from school.

Physical Health: Participants would be asked in general "How do you rate your physical health?" The feeling will be measured using a 5-point Likert scale ranging from 1 (Not well at all) to 5 (Extremely well).

Mental Health: Participants would be asked in general, "How do you rate your mental health?" The feeling would be measured using a 5-point Likert scale ranging from 1 (Not well at all) to 5 (Extremely well).

Emotional Wellbeing: Participants would be asked in general, "How do you rate your emotional wellbeing?" The feeling

would be measured using a 5-point Likert scale ranging from 1 (Not well at all) to 5 (Extremely well).

Stress: Participants would be asked to indicate the degree to which they experience stress on a daily basis, using a 5-point Likert scale ranging from 1 (Very little stress) to 5 (A lot of stress).

Procedures

Ethical approval, including waiver of informed consent, would be obtained from both the institutional review board of the University (IRB) and the University's administration prior to data collection. The explanation of the study and the study questionnaires would be distributed during general education daytime classes. Upon entry into the classroom, the potential participants who met the study criteria would be given an explanation of the study. Potential participants would be informed that by completing the study materials, they were agreeing to participate. Students who consented to participate would complete the study materials at that time. After the study materials were completed (about 10 minutes), they would be collected by the primary investigator (first author). No identifying personal information would be collected as a part of the proposed study.

Data Analysis

The descriptive statistics for demographic characteristics and study variables would be computed, and correlational analyses would be conducted to assess interrelationships among study variables.

Discussion

We estimate that the results would indicate that university students have an increased level of stress correlated with academic stress factors. This assumed finding is supported by other research indicating the same, when the academic and social experience was worse or more challenging than expected, students reported an increase in stress (Kreig, 2013).

We expect that students would vary in stress levels and what the causes of the varying stress levels would be. Specifically, we imagine that all students would report dealing with the stress that accompanies balancing being a college student with emerging into adulthood. However, we anticipate that stress scores would be lower for seniors and higher for freshman. The reasoning is that the longer students spend in college the more accustomed they would become to dealing with stress and deploying coping strategies. The first year myth (Stern, 1966) has grown less dramatic due to increased sources of information about college life. Nevertheless, because we have no source of data, we can only speculate.

Limitations of the current study

Other than the obvious lack of data and ability to conduct this study, we also acknowledge that this proposed study would be conducted at a very liberal public university and would be limited to a very small convenient sample. There is predominance of Hispanic and female students in the potential sample pool. We understand that it would be useful to draw from a non-convenient sample spanning more than one university and indicative of a sample not so populated by one ethnic/racial group.

Conclusion

College students emerging into adulthood experience increased levels of stress when they did not feel they were functioning optimally with their academics. Based on the studies we referred to for this proposal, we assume that there will be variances in stress levels based on ethnicity, financial situations, and other factors we would explore through this study. Unfortunately, because we do not have access the conducting this study, we cannot know how much these factors would ultimately affect the outcome. However, based on the studies we referred to, social support—so long as it comes from a healthy source and is recognized by the student as healthy—seems to promote stronger coping skills in the students, thereby decreasing stress and increasing wellbeing. Even though we are not able to conduct this

study, we feel confident that it would continue to emphasize and support increased interaction between students and their loved ones/support systems.

References

Ahern, R. & Norris, A. E. (2011). Examining Factors That Increase And Decrease Stress In Adolescent Community College Students. *Journal of Pediatric Nursing,* 26, 530-540.

Ickes, M. J., Brown, J., Reeves, B., & Martin, P. D. (2015). Differences Between Undergraduate And Graduate Students In Stress And Coping Strategies. *Californian Journal of Health Promotion,* 13(1), 13-25.

Kreig, D. B. (2013). High Expectations for Higher Education? Perceptions Of College And Experiences Of Stress Prior To And Through The College Career. Retrieved October 15, 2019, from http://works.bepress.com/dana_krieg/1/

Managing Stress: Principals and Strategies For Wealth And Well-Being. (2018). Jones and Barllett learning. Burlington, MA. Print.

Misra, R., Crist, M., & Burant, C. J. (2003). Relationships Among Life Stress, Social Support, Academic Stressors, And Reactions to Stressors Of International Students In The United States. *International Journal of Stress Management*, 10(2), 137-157.

Solomon, D., & Theiss, J. (2013). *Interpersonal Communication: Putting Theory into Practice.*

New York: Routledge.

Stern, G. G. (1966). Myth and Reality In The American College. *American Association of University Professors Bulletin*, 52, 408-414.

Sustaining Futures … (need full reference)

Thawabieh, A. M., & Qaisy, L. M. (2012). Assessing Stress Among University Students. *American International Journal of Contemporary Research*, 2(2), 110-116.

The framework of memorable messages

Dortell Williams

ABSTRACT

This ethnographic paper examines the formative communications I received and interpreted as a youth, and how these communications influenced decisions I made as a youth and emerging adult. The framework under which I will make this examination will be memorable messages (Knapp, Stohl and Rearoon, 1961). This framework posits that "when we share our thoughts with others, they are often unknowingly affixed to the memories of past events, and so the cycle continues" (Tilley, 2001). This seminal work of Knapp et al., is usually interrogated in positive messaging and the potential effect that such messaging has on their receivers. In this paper, I will examine the framework of memorable messaging in the context of lived experience from a negative perspective, and the harm that negative messaging can generate.

Throughout our lives we are inundated with many types of messages, some positive and some negative. The positive messages we receive as children and on throughout our lives can help us build resiliency for those counter messages that may sink in and cut, or perhaps, burrow within subtly and direct us unconsciously. The work of Knapp Stohl and Rearoon (1961) advances the idea that messages we receive throughout our lives, particularly from authority figures as youth can guide, protect and even inspire. However, there seems to be no inspection as to what effects we might suffer if the majority of memorable messages we receive are negative and deconstructive.

The negative messages and their effects are the rubric for which I will critically view the construct of memorable messages. I will use my own lived experience as context to test this construct of Knapp at all. Based on my own experience, I advance the view that memorable messages can deconstruct a receiver as well as construct a receiver. Context is paramount here, either in a positive context or negative. My experiences were negative and thus, deconstructive.

I was raised in a dysfunctional household where communications were abusive. I was called names like stupid; told I would not be worth anything; told I would be "just like [my] father," who was irresponsible, suffered from substance abuse disorder and was a chronic womanizer. My interpretation of the labeling and prognostications were that they were my fate; I could do little to avoid them. I assumed inheritance was a "controlling" factor. Nevertheless, I strove against the negative labels and predictions as best I could with what I had. Yet, striving alone, with no counter balance to these negative messages, or direct guidance as to how to avoid them, stacked the odds against me. I recall many times when I did well and was praised for my efforts, but as it turned out, it was the negative messages that had the most effect. Imagination and interpretation played their role in the negative messaging I received.

Like most children, I was a curious soul. I asked many questions, and more often than not, those questions were met with dismissals. For instance: "Mom. why did they shoot that man like that?" My mom's response was usually something like, "I don't know. Don't worry about it." Likewise, with my dad: "Dad, why did the police steal your motorcycle?" To which he would reply, "Because they are crooks!" This communication avoidance left me to my own imaginative devices. Thus, I created my own interpretations as to why people mistreat and kill other people. I assumed that it is a dog-eat-dog world, and to survive one must be ruthless. The ensuing violence I witnessed in my heme, in the

Neighborhood, on television, and at school only reinforced my interpretations. My summation of the police (all police and authority figures) being "crooks" is that they shouldn't be trusted, a conjecture that fits neatly into my larger interpretation of the dog-eat-dog world.

In addition to receiving many negative messages within the family. I also received a series of negative messages outside the home. One in particular manifested as I was approaching high school graduation. At that critical fork in the road, I approached my counselor about college prospects. After quickly reviewing my file, he noted my 2.85 GPA and that I was a class clown (seeking

either attention or to be meaningfully challenged). The counselor concluded

that I was "not college material." At that point, I made the decision to join the emerging crack cocaine trade. As a result, I ended up fulfilling all of the negative suppositions foretold of my life, culminating with a life sentence in prison. Ironically, it was in prison that I finally received the

attention I was seeking ---- but from other prisoners —- and was actually challenged beyond my boredom. It was in prison that I was able to earn my way to the Cal State LA BA prison program where I maintain a 3.9 GPA. The literary review contextualizes my assumptions that negative memorable messages can indeed be equally as destructive as positive memorable messages can be constructive.

According to the Memorable Messages construct, individuals receive innumerable messages throughout their lives, yet "there seems to be a few periods of time in which people perceive as a major influence [these messages in] the course of their lives" (Knapp, et a1., 1981, p. 27). Knapp et al., assume that the most influential messages are "typically brief; the recipients perceive themselves to be the sole target of the message, and the messages often conform to simple rule structure, for example, id-when. Exactly what was said is not important. Therefore, what is

paramount is the interpretation of the message by the receiver. According to Gidden (1979) and his definition of Structuration Theory, there are three primary concepts in social theory: 1. practices or "observable patterns of activity that are meaningful to their participants…"; 2. systems, or types of practices that build and maintain relations among, and between groups," and 3. structure, which refers to the rules and resources that communicators utilize as they take part in system practices (Lindlof et a1., 2019, p. 65). In America our structure of communication contains both connotative and denotative expressions. While denotative is overt and more precise in meaning, the connotative expression can lead to confusion as the receiver is left to interpret the exact mind of the source.

The second tenet of Structuration Theory also has three prongs; The first being that of meaning, which happens when one person interprets another person's expression by attaching a particular interpretation and action. Lindlof offers the following Hollywood action film exchange: "Was that a

threat?" "No. That was a promise." Here the meaning is nuanced and the interpretation has a potential for duality, confusion. The second dynamic of this three-prong process of Structuration Theory is power. Power is the primary influence when the source of the message is from a person in a position of authority. The final tenet are norms, which stem from the source's legitimacy, for example, their moral appropriateness (Lindlof, 2019, p. 66). Again, interpretation is king.

According to Knapp et al., regardless of how the receiver constructs or recalls the message, the most important aspect of the memorable nature of messages is how the message is "perceived," according to the receiver's current social and emotional needs (p. 36).

The reason why people remember certain messages and perceive them as more important than others is an elusive phenomena. Whatever the reasons for which particular messages remain as

memories, they have consistent components: 1. The messages are typically brief: 2. they are remembered for long periods, particularly if they comport to one's needs or belief system; 3. the receiver believes they are the sole target of the message, 4. the message often conforms to simple rules, and 5. usually the recipients were requested to participate in forming the message (Knapp, et a1. 1981, pp. 27—41). ‘

Crook and Daly (2012) argue that message interpretation has health consequences (p. 2). It is important to identify the characteristics and context of the message itself (Thoits, 1995), for example the source, valence. etc. These assumptions lead me to the following questions:

1. Can negative Memorable Messages deconstruct a person's psyche?
2. Can negative Memorable Messages from others lead to self-destructive behavior that becomes an imposed prophecy on others?

My lived experience concurs with the construct or Memorable Messages, but inversely. Rather than influencing my thoughts and actions in a productive manner, as positive Memorable Messages are assumed to do (Knapp et al,. 1981, p. 27), my life was unraveled by the effects of negative Memorable Messages imposed on me by authority figures in my young life.

As Knapp et al. (1981, p. 27) predicts, these negative Memorable Messages had a profound influence on my cognitive process, my self-concept and my ensuing behavior -- in both instant and future actions. As assumed in the literature, the form of these messages was, indeed brief and structured: "Are you stupid? (connotative). "You are stupid," "You aren’t college material," (denotative). There is no need for a Memorable Message to be a tirade. As predicted by Knapp. et a1 (1981. p. 27) a brief message is enough to permanently attach. Save for the if-when function of the

Memorable Message construct, every other aspect of it applied to my lived experience.

Believing I was the sole recipient of the message, it was natural for me to personalize and internalize the message, as Knapp et al. (1981) assert. Furthering the credibility of the Memorable Message construct, all of the messages I received were delivered by authority figures in my life: my

parents, teachers, my counselor (Lindlof, 2019, p. 66). Furthermore. Gidden (1979, as cited in Lindlof, 2019), who theorized that the "patterns of activity " in delivering messages meaningful to the recipient, are expressed in a system orientation (connotative or denotative), and are structured, such as in rules and resources (paternalistic or authoritative) (p. 66) Whether the message was delivered by my parents, a teacher or my counselor, each had legitimacy in their authority and superior experience than I, thus asserting their ethos. The internalization of these negative Memorable Messages, with little or no counter, resulted in a series or unhealthy outcomes. As a youth, I certainly had no inherent psychological resources to counter these negative memorable messages.

As Crook and Dailey (2012) argue, my cognitive health, that is, my self—esteem and natural pursuit of self-actualization were perverted as a result of negative Memorable Messaging (p. 2). The construct of Memorable Messages fit within the framework of my lived experience like a block in a polygon. And I am not alone.

My lived experience and the effects of negative Memorable Messaging seem to reverberate throughout the adult male prison system. I was able to glean this hypothesis from over 800 hours of facilitating cognitive behavioral therapy classes for my peers. During the course of ten years, I facilitated classes such as victim sensitivity awareness, parenting, and effective communication, among others. During this tenure, the vast majority of personal stories of peer participants hinged on negative Memorable Messages. Based upon my lived experience and observations, I

believe negative Memorable Messages can deconstruct a person's psyche. I also believe that negative Memorable Messages from others can lead to self—destructive behavior that becomes an imposed prophecy on the receiver.

These findings are salient because they allude to a malicious preventable pattern of maladjustment and self-destructive behavior among youth. As a society, we not only desire that our children be safe, and that others be safe in shared environments, but that they grow up to be productive, contributing members of larger society.

My lived experience agrees with almost every tenet of the Memorable construct. Therefore, as a society, we have a choice of which types of Memorable Messages we deliver. As social scientists, we possess a deontological appointment to further examine this construct with a Meta-study that includes women and non—conforming gendered people.

This study was limited to my lived experience, as compared by informal observation of my imprisoned male peers who suffer similar ills as a result of the internalization of negative Memorable Messages. Restricted to an all-male penal institution, I was very limited in scope and liberty to conduct research on a protected class, and as part of that protected class, my research was further restricted. It is thus my hope that a larger study be conducted, appraising the Memorable Message construct, from a toxic perspective and larger more encompassing lens.

The power of group therapy

Allen Burnett

Group therapy has been validated by behavioral scientists as a successful, evidence-based method for healing, problem-solving, personal and collective realignment, and sobriety maintenance, among others. The reason for the success of group therapy is that it fosters self-reflection within a support group of similarly situated individuals who offer testimonials of common tragedies and triumphs that others can learn from and apply to or avoid in their own lives. This validation comes without a professional guide. The absence of a professional guide in group therapy is acceptable because research assumes that the lived experience of the collective makes the individuals within the group the experts.

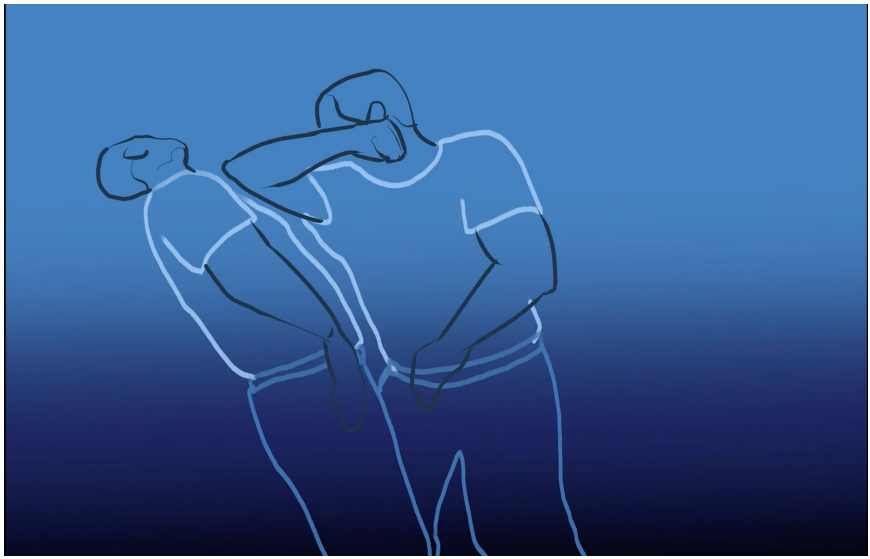
The following exercise is designed to be an impromptu practice therapy session on the topic of microaggressions. Microaggressions are slights: verbal, behavioral, and environmental degradations that cause humiliation and attack self-worth. Microaggressions are hostile or derogatory attitudes

expressed through marginalization, discrimination or negative actions against another who is seen as the "other". They can stem from implicit or explicit bias or ignorance, but result in a feeling of being minimized, categorized or stereotyped by a person of a dominant group.

The learning objective for this exercise is to gain a larger understanding of this phenomenon and to expose the commonalities of these experiences in hopes of magnifying a sense of empathy among the group. The first step is to agree on a unique set of rules as to how the group will function and behave. Such as: Will questions be signaled by raising one's hand? Is there an agreement on confidentiality? etc.

Typically, the group sits in a circle to emphasize equality, but again, this arrangement may be voted on by the group. Each person may then introduce themselves and perhaps share a sentence on how they feel, which could begin with the facilitator of the group. Once the circle has made its round, the facilitator will again lead by sharing an experience where they perceived themselves being the subject of a microaggression. Each group member can follow in succession, volunteer or wait to be called on at which time each member should have the right to "pass" (again, the group should decide the process).

At the end of the session, each member should state how they are feeling as a "check out" -- to ensure everyone is emotionally secure. The group can then set a follow up date, mix and mingle or conclude.



Q&A: Random selection of class prompts

What are some of the key differences and key assumptions between scientific and interpretive approaches to conducting research in health communication? Give two examples for how each approach applies to the study of health communication.

Marvin Johnson: [On one hand], the scientific approach to health communication research assumes that the examination of a statistically significant number of cases allows a researcher to make generalizable conclusions to a larger population of subjects. On the other hand, the interpretive approach assumes that: (1) the nature of truth is subjective. (2) Participants may hold multiple and varied meanings they must reconcile in order to communicate or co-construct a shared social reality. (3) Significant meaning situates or contextualizes. (4) The goal of research is to reveal and make understandable the subsisted experiences, and the participants' understanding of their own lives. [More so], the difference is that for the scientific paradigm, the researcher needs a larger sample population and data count to assign a value. In contrast, the interpretive paradigm allows for a smaller number of subjects and allows for a subjective application by the researcher in reference to the principle of boundary and how the phenomena researched exists in the context of the lived experience.

What is naturalism? Is it associated exclusively with an interpretive approach to research? Please explain why or why not.

Daniel Whitlow: Naturalism is a research design that emphasizes and highlights the complex experience contained within a provider-patient communication event. This includes the content of

what is said, the manner in which it is said, the environment where said, and the people involved in the interaction. Consequently, for that reason, even though naturalistic studies use predominately-interpretive approaches, the scientific approach retains an important role.

Darren Robinson: Naturalism is performing research in a normal setting where health care communication takes place. If I want to understand how people really talk during a support group, or talk to providers in a hospital room - a very stressful place - then I need to observe this give and take communicative exchange without intervening or disturbing the natural interaction - my observation as a researcher. Naturalism does not have to apply just too interpretive research. For, I, as well, could observe heaps of interaction and work towards generalizing concepts from many naturalistic observations. The ability to generalize and create larger concepts is the central idea of the scientific perspective. There can be multiple optional methods used in the scientific perspective for research purposes, inclusive of naturalism.

Give an original example to study some aspect of healthcare delivery using a naturalistic approach.

What is an intervention? Are interventions associated exclusively with a scientific approach to research? Please explain why or why not.

James Cain : An additional type of research design for studying patient/provider communication is the intervention research design. The intervention design is scientifically orientated and involves the manipulation of variables for effect. Typically, the social scientific researcher will apply this

style of research to manipulate aspects of communication between the provider and patient to see what affect the manipulation will have on the interaction. Any time a researcher is concerned with the way in which a variable affects another variable; they are

approaching the study of phenomena from a scientifically based perspective.

Marvin Johnson: A researcher uses an intervention in an attempt to determine if a health communication behavior is amenable to modification or not. An example of a scientific intervention in health care communication is the use of Donohew and Palmgreen's Activation Theory of Information Exposure to tailor a health care message to a particular population based on the overall group's

level of sensation seeking (Donohew, et al., 1980). However, interventions do not need to remain

grounded in the scientific perspective. I would argue that narratives are an area ripe for an intervention. For instance, a chaos narrative relating to illness might be subject to an intervention, where the researcher tries to change the subject's constructed worldview. Narrative studies are interpretive in nature - how does the subject see the reality in which he or she lives? However, a researcher might select subjects that produce chaos narratives (where the individuals feel that their lives have spun out of control because of illness) and target these individuals for an intervention with the desired result being a change of the subject's view of his or her reality.

Dortell Williams: During the presentation of Mosley, Walton, Evans and Crespin, it was impressed upon me how the course text, a rather simple text honestly, was actually reiterating the approaches to general research, but in the Health Communication context. Of course, our papers are based upon approaches such as the choice between scientific or interpretive. Rather than given a topic and then asked to design a research paper, the approach of this text is to give us situations or context and to then consider if it is scientific or interpretation. Speaking for myself, this approach caused me to think about the same things trained to consider, but in a different way.

Duncan Martinez: As we look at these topics, one thing paramount is that communication means everything in health

settings. The importance is not one-dimensional, either: everyone has not only needs, but also responsibilities in the arena. We think of doctors and their ability to communicate as key--we think of this as 'bedside manner'. That is only one aspect of true communication. Yes, they have to have an understanding of how to keep their patients at ease. Going deeper, the provider needs to ensure that the patient clearly understands the communication. This is just as true for the patients to ensure that the provider understands what they have to say or express. The patients need to understand that they have a tremendous responsibility in their own health: if they do not say something, they are the ones who will lose. Everyone involved shares responsibility.

Group Interjection

We agree, as quoted in the Reader, the paternalistic model of healthcare is provider directed and hierarchical even though patient care often requires open dialogue among patients, providers, and family members (Jones & Stubbe, 2004). These roles traditionally develop predicated on task-oriented and verbally prevailing discussions between doctor and patient (Graugaard, Holgerson, Edie, & Finst, 2005). There is also the biomedical model that integrates, communication mirrors, the scientific approach converging in hard science, for example, physiology, biochemistry, and genetics - without trepidation whether or not the patient comprehends the issues. This model dominated the 1970s and 1980s ousted only by research that confirmed how patients' psychological, social, and relational physiognomies work - in union with biological matters that form the patients' understandings with disease and sickness. Accordingly, this resulted in the more state-of-the-art bio-psychosocial model of care that defines the patient as a whole person - not just as a set of biological symptoms and test results (Engel, 1980). This clinical interviewing in healthcare approach manifests an opportunity regarding the interpretive approach to medical care based in the constructivist framework (Delia's, 1977), (Health Communication Theory, Method, and Application, 2015). The above-mentioned are

the challenges that the patient faces when communicating with their healthcare provider. We as researchers seek ways to improve the communicative interchange between all involved.

For example, clinical equipoise involving more than one treatment method will allow the patient enhanced information concerning ailment(s) and affliction(s). Additionally, concordance permits patients to experience motivation similar to shared identity orientation - doctor/patient communication. The importance relates to decrease in medical error(s) lessened by the patient's informed ability and knowledge concerning treatment and how it is managed. The patient-centered communication approach reacts directly to the needs and aspirations of the patient and it rotates around three core attributes: (1) consideration of patients' needs, perspectives, and individual experiences (2) provision of opportunities to patients to participate in the care, and (3) enhancement of the provider-patient relationship (Epstein, et al., 2005).

Epilogue

The scientific and interpretive approaches to research concerning provider-patient communication establishes that communication is quantified by high quality scientific research studies that measure behaviors that show that this specific communication process directly impacts healthcare delivery - including quality, safety, and other phenomena. That is tightly fitted measurements can show both direct and indirect effects on health and health outcomes.

Naturalism as it pertains to this subject incorporates the naturalistic research design and seeks to describe settings, occurrences, and interactions in terms of what is said - the content, how it is said - the manner, where it is said - the context, environment, and to whom it is said - the participants. Naturalism is an orientation or method that values investigating the total environment within which the communication and other factors interact all-inclusive.

Subsequently, these components are interrelated; naturalism recognizes that communication occurring between participants is

more than the sum of its individual parts. In naturalistic observation, the observation transpires in the actor's natural environment and behavior is disturbed as little as possible by the observation process; often, the actor is unaware of being observed - participant observation uses audiovisual recording to capture as much detail as possible. For this reason, naturalistic observation is also known as unobtrusive/inconspicuous or non-reactive research so as to emphasize that actors do not react to the presence of the observer (McBurney and White 2007). See also Extraneous Variable/Evidence, Laboratory Research.

Interventions connect exclusively with scientific research since tightly fitted measurements can show both direct and indirect effects on health and health outcomes. Intervention research design methodologically manipulates some aspect of patient-provider communication to see what effect the manipulated variable has on outcomes of the interaction. This is accomplished by use of audiovisual recordings, surveys, or interviews to capture as much detail as necessary. For instance, scientific and interpretive analysis use transcription similarly in that they both predicate measures of behavior ascertainable to show that specific communication processes directly influence healthcare delivery, including quality, safety, and other phenomena. For example, scientific analysis consists of coding frequency and type of talk. Interpretive analysis encompasses coding single cases, collections of cases, or deviant cases for key interactional features. The scientific strategies apply interaction analysis systems to the recorded consultations such as coding frequency and type of talk. The interpretive strategies pertain to transcribing and analyzing the communication. However, a patient must be proficient in health literacy - the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions that may affect their health and the ability of the healthcare system to provide effective high-quality care. It consists of four components: (1) cultural and conceptual knowledge, (2) oral literature, (3) print

literacy, and (4) numeracy. Physicians are at this time trained in listening, speaking, writing, reading, numeracy, and skill differentiation, authority differentiation, and temporal stability.

In other words, subjective research in reference to doctor-patient communication examines the exchange and interchange of the communication between doctor and patient in a medical encounter, tracking how the doctor's behavior influences the patient and vice versa. However, due to the complexity of conducting that type of work, seldom is it done. The limitation in this area of study has primarily fixated on communicative behaviors enacted by the doctor in the medical encounter (Cegala and Street, 2010).

McBurney, Donald H., and Theresa L. White. *Research Methods*. 7th ed., Thomson Wadsworth, 2007.

Thoughts on the *Teach Back* method

Jesse Crespin

This is a brief description of two recent encounters I had with the dental department. I feel compelled to share these experiences because they are a real-life enactment of our Health Communication class. Although there were two very different encounters, they both revolve around the same issue — the treatment plan for one of my teeth. Both encounters encompassed very different communication styles, styles that were performed by both the dental professionals I encountered, as well as myself.

Firstly, let me briefly describe that, in order to actually see the dentist, a prisoner needs to fill out a medical request form explaining an issue they are having. Once the prisoner turns in this paperwork, it is reviewed and then an appointment is made — keep in mind that this process can take up to a few weeks or even a month. Sometimes, if the issue is severe enough, the prisoner might be called in right away, however, that is not the norm. But, to those of us who are incarcerated, that is what almost seems normal, because we are currently living in an environment that encompasses an ineffective healthcare communication system. Oddly enough, even though there are a lot of people who have medical issues that need to be attended to, the medical system performs the least amount of work by leaning on their paternalistic approach to treating their patients with "you're okay, because what I say goes."

The sad reality is, this seems to be a reasonable explanation as to why — after turning in a medical request regarding some form of healthcare issue — it takes so long to be seen. As for me, well, I needed the dental office to refill a filling that had fallen out.

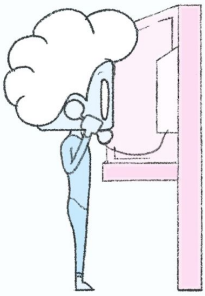
The pain I experienced was minimal, but still irritating nonetheless, yet it took well over three weeks to hear from the dental department. My initial encounter with the dentist was wrought with a paternalistic — almost verbally assaultive — approach based solely on what seemed to be my status as a prisoner. As I tried to explain that a filling had fallen out, the dentist interrupted me by saying that the tooth in question never had a filling — even though the x-ray of the tooth still showed a fragment of the filling still attached. What's worse was the dentist's statement that the only way to treat my tooth was by pulling it out. I asked why couldn't it just be refilled, and was told that if I wasn't a prisoner, my tooth could be treated appropriately, but because of the fact that I'm a prisoner, they were not going to treat it as salvageable. So, I asked for some information about the policy/procedure from which they were basing their decision on and was told that I would be rescheduled in about a month for an appointment to pull my tooth.

Although I never received an answer to my question regarding the policy/procedure behind the dentist's decision-making process on how to treat my tooth, I felt that a month was enough time to inquire about it, so I did. After turning in the necessary paperwork, I waited for a response that never came. What did arrive, however, was an appointment to see the dentist to undergo the procedure of pulling out my tooth. So, I prepared myself to become an active participant in the decision-making process regarding the treatment of my tooth, which lead me to the PACE process discussed in our textbook. What resulted from using this technique was a very positive and effective communication encounter that seemed to be way more patient-centered than the initial encounter.

After, letting the dentist know that I was present, by explaining my concerns regarding the removal of my tooth, I asked a series of specific questions I had prepared beforehand. During this process,

I also checked in with the dentist to make sure that I had a clear understanding of what was being said — I did this by using the teach-back method; by repeating in my own words what the dentist was telling me. Although the treatment plan was still the same — to try to pull my tooth — the dentist responded to my questions in a more patient-centered manner. This type of encounter elicited a sense of empowerment, where I felt comfortable, as well as confident, in expressing my concerns regarding the plan proposed for treating my tooth.

Overall, I was satisfied with the latest encounter I had with the dentist, and today I still even have my tooth — it just hasn't been treated yet. Nevertheless, when people invest a little bit of time and energy into trying to communicate effectively — especially with a healthcare professional — then they can contribute to the process of triggering a more positive encounter.



On the evolution of the trauma informed approach

Robert Mosley

Post-Traumatic Stress Disorder (PTSD) was not defined until 1980, even though we named it before as "Shell Shocked." Now, in 2019, the symptoms designate as Post Traumatic Syndrome (PTS). Because of accuracy failure, the 'D', for 'disorder' was eliminated. The 'D' presents psychosocial dysfunction, a category (much like shell-shocked) without favorable implications for the majority of the impacted persons. A 'syndrome' may represent a condition or pattern, without including the 'disease' connotation. Trauma may be physical, social, or psychological. A 'financial trauma' is an example of a psychosocial trauma. Each type may convey some type of PTS. Consider the impact of a trauma.

There are three impacts of trauma. First, in the emotional brain there exists reliance on basic, or inherent, automatic responses. Fight or Flight represents a hostile token of powerful negative emotions. These automatic responses gain stimulation from traumas. Second, an alarm system in the brain becomes terribly distorted — perceiving danger everywhere. This happens with continued high volume of similar traumatic experiences. Third, trauma's perceivable impact's meter is the ability to appraise, balance, enjoy, and rationalize experiences.

Two methods of handling traumas are to excuse them or justify them. By excusing, one acknowledges the trauma, but denies responsibility for it. Excusing may include refusals and apologies or 'concessions'. A full apology, the more readily and socially acceptable excuse, indicates five steps: 1) Expression of remorse; 2) recognizing a more appropriate action, (that could have been taken); 3) rejection and disparagement of the misbehavior; 4) expressing intention to behave appropriately in the future; 5) penance, or an offer of compensation. A person may apologize

even when they are not the origin of the trauma, nor a participant in the delivery of the trauma. By justifying, they may deny, minimize, associate a higher loyalty, or rely on some sad story as rationale for the experience. Justification usually accompanies developmental traumas.

Developmental trauma does not heal instantly, it takes time to heal. We must be able to access a calm brain. Look at the work done by the Center for Disease Control (CDC). The CDC's studies conclude that childhood trauma is the single most powerful predictor of progressive public health. Childhood trauma happens in the crucible of relationships. We help people heal when we promote communicative connections, both internal (personal) and social. Revealing and confiding traumatic experiences through narratives may generate a greater understanding and unburden the emotion from the act of concealment. Concealment, usually immediately accompanies traumatic experiences. Concealment may occur through defining 'trauma'.

What does trauma mean? The tendency of definition causes us to associate “trauma” with “problem”. Oftentimes we are unable to recognize and admit that the source of our problems is ourselves. As part of the internal connection, it serves to realize that whenever you seek to divorce yourself of a problem, you must eliminate the problem at the source. Ideally, you are the source of the problem. The “problem” needs not be a “problem” for all. A (the) “problem” does not have a “problem” with itself but may have a “problem” with you. In which case you need to understand why (it) is a “problem” for you. This is a practical and experiential wisdom. You must beware though, because problems are like poisonous snakes. If you get too close to them (the poisonous snakes), or comfortable with them, they can cause harm to you. However, you have great difficulty avoiding them throughout your life. The act of avoiding them may itself be a traumatic experience.

In dealing with, and communicating traumas, some of us have been taught, "If it doesn't kill you, it will make you stronger." However, all 'killings' do not occur instantaneously. Some poisons take time to complete their destructive actions. In the same way, some traumas take time to reveal their destructive effects and simultaneously, dealing with the trauma, becomes traumatic itself. How are we going to teach back? How are we going to deal with the traumas in our lives? Is there an objective (true) standard (empirical) definition of trauma? On the other hand, is trauma a subjective experience?

A limitation in the definition of trauma is that it only denotes a negative experience. Some traumas can be reframed as both positive or negative. Consider, for example, the physical trauma that must take place during surgeries. Often many people experience trauma and are unaware of it or so conditioned to the experience they do not realize it as trauma. However, a surgery does qualify as a significant event.

Categorizing and identifying significant events in the traumatic category better enables conceptual management. Thinking of traumas as significant events in your life, you are able to look back with 20/20 vision seeing when and how you made decisions which affect your current life's position. Unlike most things in life, traumas can be predicted. However, their total effects still are rather random.

Trauma comes with living. For some entities to live, some others must experience trauma, up to and including death. This comes as part of the 'chain (or Cycle) of Life'. Living is similar to white water rafting on a relatively uncharted river. At some places, the current is explosive, and at others, it is calm. There are submerged boulders and other flotsam undetected until you are in contact with them.

Most of the time, as you slow down and look at a situation objectively you realize harmful events, that you considered significant events in retrospect, as potentially avoidable. However,

there are some perpetrated upon you, regardless to how much energy you expend to avoid them, and others that come upon you like a black ant on a black rock at midnight on a night with a new moon. That you survive, to reflect upon your experiences, designates your resilience, which in turn makes you stronger. Then, the quality of your survival (the degree or magnitude of your resilience) represents how you deal with the contact, if you still live.

Resiliency in motion and best practices in health communication: Closing thoughts

The following are the various roads of resiliency that the students have traveled. Many of them initially had no resiliency and they resorted to the phenomena called trauma reenactment. This is where people respond to their traumas in negative ways. Resiliency is the ability to overcome adversity. It is the mental ability to quickly recover from depression, illness or misfortune. Below are some of the ways that the authors in this collection build and utilize resiliency as a health communication practice.

Stephen Houston:
I practice positive thinking, which is fortified by my spiritual beliefs. I have defied the odds against multiple sclerosis, so I look back on my past success to propel me forward. I know that any given adversity isn't the end of the world, I count my blessings and always consider how things could be worse. I think it is important to realize the importance of trauma, and then recognize how it affects us individually. Once I did this, I put the knowledge I have about trauma into practice. This is how I reduce the harm of stressors. Personally, I believe in strengthening my personal and healthy relationships as a means of resiliency.

Allen Burnett:
I believe in empowering people with the information that could expand their lives. In my family, there is a history of diabetes, heart disease, and stroke. Health Communication, as it is explained in the CDC and NCI definition possibly could have had a tremendous effect on my family's overall health, as well as my community. I practice positive thinking, recognizing the things I cannot change, and dealing with adversity head on (for the things I can change). I remind myself of the refrain: "This, too, shall pass."

I also try to foster relationships with positive people, and I trust my higher power.

Dortell Williams:
I recognize through research that beliefs and attitudes equal action. So, I try to maintain balanced beliefs by maintaining healthy relationships with positive and successful people who can give me constructive feedback. I go to people who I know care for me and mean me well. I also try to do healthy practices: getting seven or eight hours of sleep, eating in a wholesome way and exercising regularly to reduce stress. I also recognize my triggers and counter them with coping strategies like patience, avoidance of negative things, and going with the flow when it's out of my hands or too small to worry about. Sometimes I just have to let things --situations or things people say or do-- go.

Jarold A. Walton:
I like reading self-help literature and being in touch with family and my college associates. I also exercise, avoid negative people, take responsibility for my actions and try to make connections with people in my profession. I like to think and say positive affirmations out-loud to myself. I also like to stick to a schedule of positive rebuilding. And I make sure to avoid the company of those who are not like-minded. Health communication is about sharing the truth about health. Only when you involve the people who are "living it", can you get the real answer.

Tin Nguyen:
By using the paradigms inclusively in the research of service dog training, we may obtain data that reveals the dynamics of service dog training in health communication.

Marvin Johnson:
Disease doesn't just affect health, it causes suffering for the afflicted patient, his or her family, friends, and even strangers who meet or engage with the person.

Darren Robinson:
People can get really sick and not be heard. I broke my neck several years ago, and because I was being treated for a serious condition, the doctor didn't hear my complaint.

Thomas Wheelock:
Active listening is so very important in doctor/patient care. The communication between the two groups can become strained as there is communication loss. You have to hear what the other party is saying and not just what you want to hear.

Duncan Martinez:
...the most important part of health communication is the interaction between the doctor and the patient. It is central to everything else that happens, and, if poor, can lead to serious problems that are hard to get past.

Daniel Whitlow:
The more we understand about what may happen if messages get scrambled or missed all together between patient and physicians, the better we can refine communicative techniques and prevent confusion.

James Heard:
It is critical to create a basic definition for researchers, teachers, and laypersons alike to encompass the broad scope of health communication. After reading this text, it is my goal to create a definition acceptable to the layperson, academics ,and professionals.