Weathering and Social Determinants of Health as Powerful *Topoi* in *RHM*

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As we present this second issue of volume seven to readers, we want to continue the incisive and generative reflective work that our guest editors have done in the "In living color: Amplifying racial justice work in RHM" (6.2—Kimberly Harper, Veronica Joyner, and Maria Novotny) special issue and in the "Queer and trans health justice: Interventions, perspectives, and questions" (7.1—McKinley Green, Wilfredo Flores, and Fernando Sánchez) special issue. In both cases, these guest editors center marginalized persons and their experiences in health and medicine and amplify scholarship in the field and beyond that also does this important work.

Thinking of these key contributions, we find ourselves reflecting on the biomedical monoliths that, in their day-to-day practices, continually fortify their ideological dominance and produce and reproduce marginalization, such as major pharmaceutical companies and for-profit hospital networks. These entities tend to overwhelmingly suggest that a person's body and what happens with and to it are a matter of personal choices—a person makes either good choices or they make bad choices—and that overcoming the various ways that we have failed ourselves is a matter of not only making lifestyle changes, but also of opting into the right surgical or pharmacological regimens or both. Too often, the various things that are simply beyond a person's control are subjugated under these things that

we are supposedly responsible for. In the same way, we noted that, early in the COVID-19 pandemic, when an otherwise young and healthy person died of the virus, there was buzz about an unknown "underlying condition"—always with the insinuation that the person ought to have known about and gotten treatment for that ailment and, thus, saved their own lives.

As Stacy Overholt and Amanda Friz (2023) explained in the final issue of volume six, healthism, or the notion that a person's health is entirely their own responsibility and that failing to live "correctly" where your body is concerned leads to illness, relies on similar logics—if you take good care of your body, you enjoy the wellness you deserve. If you fail to take good care of your body, you get your punishment in the form of illnesses. As Danielle Mollie Stambler (2022) has similarly argued, workplace wellness programs tend to create conditions in which some employees are framed as unable to participate in the pursuit of wellness as these programs define it and are, thus, marginalized. In the same way, Colleen Derkatch's (2022) work has convincingly demonstrated how the powerful pull of wellness culture leads to a never-ending quest for wellness, which is always a moving target and is never ultimately attainable—even as consuming wellness products might make people feel in control of their health.

Such logics of blame are suffocatingly present in the popular opinion or *doxa* surrounding health and medicine around the globe, and many are blamed for their own suffering as a result. What is more, biomedical behemoths through time have done far worse than blame people for their health profiles. In many cases, active harm has been done in the name of medical advances, and, as John A. Lynch (2019) has argued, such events are often minimally remembered in ways that allow for the claim that some commemorations have been made when adequate reparations certainly have not, and sufficient lessons have definitely not been learned. Even with well-known atrocities suffering from minimal remembrance as Lynch has theorized it, others are likely still buried.

Relatedly, recently it came to light that poor Black children in the 1960s were victims of medical experimentation without the knowledge of their families, and when two Black baby boys died before they reached their second birthdays, their families continued to suffer their losses for decades. When their families were told that these babies died because of vaccine experimentation—the same experimentation that led to today's RSV vaccine—they were devastated, but not at all surprised. As Charles M.

Blow (2023) opined, "That lack of surprise is the scar tissue that Black Americans have built up — the knowledge that the worst is always possible. The mind and spirit continually make space for it, forever hoping, but preparing contingencies for hope's inevitable betrayal" (n.p.). The recent special issues alongside such narratives and ideologies of patient blame reinforce the need for rhetorical interventions to challenge dominant narratives related to health and wellbeing and to continue to push the boundaries of the field outward in ways that also center marginalized health and medical experiences and perspectives.

Moreover, it is particularly powerful when potent new theories enter the scene to contradict these problematic equations between personal behaviors on the one hand and responsibilities and health outcomes on the other. One such theory is the "weathering hypothesis," which "states that chronic exposure to social and economic disadvantage leads to accelerated decline in physical health outcomes and could partially explain racial disparities in a wide array of health conditions" (Forde et al., 2019). Weathering, to be clear, though, is not simply a theory. In a systematic review published in 2019, authors Forde et al. overviewed 41 studies that provided clear empirical evidence in support of weathering as a phenomenon that exists. As Arline T. Geronimus (2023) explained in her book *Weathering: The extraordinary stress of ordinary life in an unjust society*, weathering, her coinage, accounts for how a person's very body becomes old and worn out well before its time due to socioeconomic and racial injustices. When stress is not matched with adequate social support, it leads a person to be weathered severely, often at young ages.

Weathering has echoes of another set of theories—the social determinants of health or SDOH, or, as the World Health Organization (WHO) (2023) explained them, the "non-medical factors that influence health outcomes" that include things like "income and social protection, education, unemployment and job security, working life conditions, food insecurity, housing, basic amenities, and the environment, early childhood development, social inclusion and non-discrimination, structural conflict, and access to affordable health services of decent quality" (n.p). That said, SDOH have been criticized for, among other things, their lack of ability to lead to potent policy and practice interventions (Frank et al., 2020), and weathering has been critiqued for failing to provide "a synthesis of life expectancy tables with the weathering hypothesis and allostatic load scores" (Thomas, 2006, n.p.), yet they are still worth considering as

potentially powerful alternatives to the dominant narrative that you are what you made yourself into all on your own.

What is so powerful about weathering and SDOH, too, is that they directly challenge the ideological foundations of powerful medical institutions in their contradiction of the notion that good health outcomes are a matter of good behaviors or virtuous personal attributes, and that poor health outcomes are the result of poor decision-making and bad character. The existence of weathering and SDOH urges us to do more than simply argue that biomedical models of care could do epistemological damage. They call on us to also acknowledge the variety of ways that factors that would appear to be outside of the realms of health and medicine are very much a part of that milieu. As we write this introduction, for example, Hamas has taken innocent Israeli citizens hostage under the threat of execution after an indiscriminate and brutal attack in which many innocent lives were lost. Meanwhile, those in Israel are hiding in bunkers or being hastily moved to safer locales, and innocent, already heavily disenfranchised Palestinian civilians are also being mercilessly slaughtered in the conflict. All innocent persons caught up in this conflict are suffering a wide variety of mental and physical effects that are very much to do with health, yet, arguably, none of their own behaviors have led to these outcomes.

As a community of scholars across the communication disciplines, we want to continue to mobilize work that operates at odds with the logics of biomedical monoliths and the toxic *topoi* that allow them to perpetuate the idea that what a person's life looks like in terms of health and wellness is their own doing.

In this issue, we are pleased to present work that does just that. In the lead article for the issue, Davi Thornton shows how stigma—a potent *topos* and a concept regularly invoked as the cause of suffering for the so-called mentally ill and one that psychiatry has continually claimed it is working against—is also ironically the basis for psychiatric care. Without stigma, argues Thornton, psychiatry would not be able to maintain its status as a scientifically driven and humane enterprise that is aligned with better futures.

Next, in Mary Schuster's "'Crafty' rhetoric: Legal advocates intervene for survivors of domestic abuse," she builds on mental health rhetoric research (MHRR) to explore how legal advocates in non-profit organizations guide survivors of domestic abuse in obtaining orders for protection

(OFPs). Recognizing that state statutes reflect cultural and structural biases about domestic abuse, Schuster performs rhetorical analyses of state statutes alongside interviews with legal advocates to reveal how advocates engage in subversive rhetorical intervention that they call "crafty" in that they manage to meet the requirements of state statutes for an OFP while also providing a way for survivors to tell their stories on their own terms—a move that helps survivors begin to heal from the trauma of domestic abuse while also persuading judges of the need for OFPs and demonstrating that domestic abuse statutes are likely too restrictive.

We are also pleased to include Jaci Wells' "Just follow the (ten) steps: Breastfeeding education in baby-friendly hospitals," which presents an investigation of infant feeding rhetoric from the Baby-Friendly Hospital Initiative (BFHI), a WHO and United Nations Children's Fund (UNICEF) partnership that prioritizes exclusive breastfeeding. Approaching patient education materials as user documentation and analyzing the materials for *kairos* and metaphor, she argues that the materials promote the metaphor of body-as-machine and do not always account for families' diverse situations.

Moreover, in a powerful example of RHM work that engages with the concepts of weathering and SDOH and also pushes back against biomedical monoliths is McKinley Green's commentary, co-authored with members of the Youth and AIDS Projects (YAP) at the University of Minnesota, including Val Crutcher, Océane Lune, Munira Mutmainna, Racquelle Lenoir, Andrew Schuster, Gage Urvina, and Calla Brown. Reflecting on a study they did to investigate how young people living with HIV navigated the COVID-19 pandemic, they offer concrete methodological approaches to studying health inequity. Readers will find rich descriptions of participatory and narrative-based methods as well as explanations of how these approaches helped the team develop five specific study protocols that reflected their commitments to equity in research: revising questions to account for local conditions of risk; intervening in histories of extractive research practices leveraged against communities at the margins; phrasing demographic questions to account for the complexity of identity; incorporating consent iteratively across the study; and offering incentives that were consistent with participants' expertise of their own lived experiences. If we are to hope to tap into the rich rhetorical affordances of terms like weathering and SDOH, we need to find ways to engage in sustained, ethical research with marginalized communities, and Green and collaborators

follow other scholarship in RHM that has discussed ethical orientations to research. Finally, we are excited to include a review of the brilliant Molly Kessler's book *Stigma Stories: Rhetoric, Lived Experience, and Chronic Illness* (2022) by Martha Sue Karnes. As Karnes notes, Kessler's work as a patient-researcher is inspiring, thoughtful, and hopeful as RHM scholars continue to examine the ways that disability, stigma, and intersectionality make meaning in the worlds of health and medicine.

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