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OPENING UP THE ECHO CHAMBER: TEACHING CULTURAL COMPETENCE IN CONTENTIOUS TIMES

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Abstract
In recent years, political discussion and social life are increasingly concentrating in face-to-face and online echo chambers composed of individuals with similar world views. This segmentation of civil society has stymied in-depth and respectful communication across ideological difference and in the process contributed to the divisiveness that characterizes political discourse across the globe. In this article, I examine how anthropological learning and teaching can help open up these echo chambers and promote cultural empathy and cross-ideological communication. My discussion focuses on three methodologies I use in my undergraduate-level Culture, Health and Healing course – weekly critical analyses on contemporary health issues, an in-class illness narrative exercise, and a term-long public service announcement project. For each, I describe the pedagogy, present examples of how the assignment or activity plays out in the classroom, and consider how these pedagogies work toward increasing cross-cultural/ideological understanding and communication. I argue that through unsettling students' default frameworks for thinking, reflexive and emotionally engaged anthropological teaching and learning can play important roles in laying the epistemological, affective, and ethical foundations for future professionals and engaged community members in today's contentious times.

Introduction
On Wednesday, November 9, I arrived at my 8 a.m. Urban Anthropology seminar, only 12 hours after election results indicated that Donald Trump would be the next President of the United States. Like much of coastal urban America, progressive Portland was in state of shock, and I approached this class with trepidation. I suspected my students would be unsettled, and perhaps angry. Yet, I saw this tense moment as an opportunity for us to apply anthropological theories and methods to unpack an extremely divisive election. So after letting students vent their emotions for 20 minutes, I decided to refocus our discussion and asked "Why do you think Clinton's messages did not connect sufficiently with voters to elect her President? And why did Trump's message of 'Make America Great' resonate with enough Americans to get him elected President." The initial response to these prompts was muted, and from their comments, I sensed that at least at this point in time, students were not interested in considering why these "racist," "sexist," and "immigrant-phobic" "others" had supported and voted for Trump. In response to further probes, students also shared how they mostly live in face-to-face and online echo chambers and rarely have in-depth conversations with those who have different political orientations and world views.

This discussion reinforced my deepening commitment to developing pedagogies that systematically address the affective dimensions of critical thinking and social action. I find that while most of my students are readily able to accept the idea that cultures may have different ontologies and epistemologies, as the above classroom vignette shows, even anthropology majors face significant challenges – and discomfort – in applying anthropological relativism to political pluralism within

their own society. Over the past five years, I have been refining the ways in which I attempt to foster cultural empathy and help students develop a skill set for applying such dispositions in their work and lives outside the classroom. In this article, I examine these pedagogies in action through focusing on Culture, Health and Healing (ANTH 325), a course I regularly teach at Portland State University (PSU). As in many US universities, these general education courses are often students' first systematic exposure to the anthropological concept of "culture" and its offspring that are commonly used in the health, social service and education professions (e.g., cultural competence, cultural diversity, cultural pluralism, cross-cultural communication). And with the highly politicized and emotionally saturated nature of health practices and policy in the US – consider, for starters, the Affordable Care Act, reproductive health, opiate addiction, and obesity/food systems – the course provides numerous opportunities for applying anthropological learning to charged public policy issues. I argue that through unsettling students' default cognitive frameworks, reflexive and emotionally engaged anthropological pedagogies can play important roles in laying the epistemological, affective, and ethical foundations for future professionals and engaged community members in today's contentious times.

The Course

Culture, Health and Healing (ANTH 325) is an upper division anthropology course at Portland State University (PSU), a 29,000 student, higher education institution in Portland, Oregon. Since 2013, I have taught ANTH 325 each year with class sizes of between 40 and 65 students. Mirroring overall university enrollment statistics, approximately 30% of students are people of color, and the course attracts higher proportions of first-generation college (40% v. 31%) and female (70% v. 53%) students than PSU as a whole. Like many third year courses at PSU, students may use ANTH 325 to meet the university's "Upper Division Cluster" general education requirement. In the case of the "Healthy People/Healthy Places" cluster, of which ANTH 325 is a part, students take three classes from a list of more than 30 junior-level social science, humanities, education, public administration, urban studies and planning, and public health education courses. ANTH 325 enrollment is typically one-third pre-health profession or community health majors, one-third anthropology majors, and the remainder social science or humanities majors interested in anthropology and health.

Over the 10-week quarter, we explore how anthropologists apply their insights to health and healing. Our first unit investigates how different cultures – and diverse individuals within given cultures – experience illness, health and healing. Next, we examine medical pluralism in US and global contexts. Our third unit considers how structural factors contribute to health disparities, and we conclude by looking at public policy and political action in support of healthy communities. By the end of the course, students will have (1) increased understanding of the connections between culture, political economy, health systems, and health outcomes, (2) raised their awareness of their own cultural beliefs and epistemological biases, (3) explored the emotional dimensions of health, healing, and the health professions, and (4) developed an expanded toolkit for their future careers.

As many students in ANTH 325 will ultimately work in the health or social service professions upon graduation, the course places particular attention on helping students develop a critical understanding of cultural competence, which in recent years has become a central strategy in efforts to reduce health disparities in the US. Although the concept has somewhat different definitions across health and social service professions, most cultural competence initiatives share an underlying premise – raising providers' understanding of cultural difference will result in better services for disadvantaged communities, thereby leading to improved health outcomes. Yet, culture competence initiatives

frequently use "culture" as a synonym for essentialized and individualized difference, and in the process, may ultimately mask the political economic dimensions of health disparities. In contrast, our starting point in ANTH 325 is a process-oriented anthropological approach to "culture" and "culture competence" (Carpenter-Song, Schwallie, and Longhofer 2007, Willen and Carpenter-Song 2013) that encompasses (changing) beliefs, attitudes and traditions as well as the dynamic political economic systems in which health-related practices are situated. By examining public health epistemologies through an anthropological lens, the course seeks to help student negotiate these complex praxis terrains and become cultural competent professionals who understand the affective, social and political economics dimensions of health and healing at individual, community, national and global levels.

While emphasizing anthropological theories and methods, the course affirms that there are multiple ways to conceptualize health and healing – and indeed, the world – each with its own epistemologies, utility, and limitations. This polyvocality mirrors the students' diverse disciplinary perspectives, and our classroom discussions consciously promote interdisciplinary dialogue, a possibility that may not be present in health-related professional schools and anthropology seminars. At a broader level, the course seeks to break down the walls of the echo chambers in which many of us live today and encourage students to communicate in a respectful and empathetic manner with those who may hold markedly different views. In the case of PSU, where students are disproportionately liberal/progressive, promoting multivocality involves providing a safe space in which students can affirm—and question—their own beliefs while strategically inserting the generally absent voices of those with more conservative perspectives. My goal is to at least for a moment destabilize the dichotomized caricatures of contemporary US political discourse (e.g., the media as fake news, Trump voters as sexist racists), as I believe that these formulations are more likely to engender political posturing than understanding, communication, and the possibility of consensus building across shared interests.

The Course in Action

Having provided an overview of ANTH 325's structure and pedagogic orientations, I turn my attention to three course components that seek to promote anthropological understandings of health and develop foundational skills related to cultural empathy and cultural competence. These are weekly critical essays, an in-class illness narrative exercise, and a quarter-long Public Service Announcement Project. For each method, I describe the pedagogy, present examples of how the assignment or activity plays out in the classroom, and consider how these pedagogies work toward increasing cross-cultural understanding and communication. Although health-focused, I believe these techniques are equally useful for applying anthropological teaching and learning to other contemporary divisive issues, such as race relations, transgender restroom access, immigration, Brexit, and globalization.

Weekly Critical Essays. Each week students write a two-paragraph critical analysis that applies a theoretical concept from the readings to a concrete, contemporary health issue of their choosing. This exercise is challenging for both anthropology and non-anthropology majors, who at this point in their educational careers are more accustomed to re-presenting empirical content than advancing their own arguments in a context of epistemological plurality and conflict. As students are not familiar with most of the theoretical concepts presented in the course, the exercise also requires them to apply perspectives that may be outside of their epistemological comfort zone. In practice, the weekly writing exercise develops students' self-reflexivity (Cunliffe 2016, Gilmore and Kenny 2015)

and narrative humility, the "awarenessg of one's prejudices, expectations, and frames of listening" (Tsevat et al 2015:1462), with the goal of helping students better understand how their own perceptions may shape health practices, systems and outcomes. And by providing a low-risk opportunity to try on different conceptual approaches, the critical analyses seek to promote students' self-efficacy (Hall 2014) in working with culturally and epistemologically heterogeneous communities and colleagues in their future careers and community engagements.

Illness Narrative Classroom Exercise. As anthropologist Sarah Willen (2013:258) argues in her analysis of cultural competence curricula for psychiatric residents, experiencing difference is both an emotional and cognitive process. Pedagogies that ignore affective dimensions may not support the development of cultural empathy and the production of culturally competent health and social service practitioners, anthropologists, and community members. Yet, critically assessing emotions in the clinic or classroom can "open up a huge can of worms" (Willen 2013:258) of discomfort, confusion and conflict, possibilities exacerbated in today's polarized political environment. In ANTH 325, we enter this unsettling affective terrain through the medical anthropological concept of illness narratives (Kleinman 1988, Mattingly and Garro 2000), the stories patients, families and providers tell about the experiences of symptoms, suffering and treatment. We begin with a "quick think" classroom exercise in which students, in response to my probes, write an ethnographic vignette on a time when they or someone close to them sought the assistance of a healer or health promoter and then discuss these narrative in small groups. This exercise consistently generates reflections on a wide range of healing systems (e.g., biomedicine, chiropractic, Chinese medicine, Curanderismo, homeopathy, Reiki, self-help) and illness situations (e.g., chronic pain, colds and flus, injuries, mental health issues, living with cancer). And because not all students believe in the efficacy of all of these healing techniques, they are forced to consider how to share their opinions with their classmates in a manner that is respectful of the epistemological differences revealed in their illness narratives.

As the illness narrative exercise occurs during the second week of the course, students do not yet possess a rich anthropological conceptual toolkit to fully analyze the many dimensions of the situations they describe. So not surprisingly, and mirroring illness narratives from the medical anthropological literature, most students highlight the emotional dimensions of understanding diagnoses, achieving behavioral change, and experiencing patient-provider relationships. In our concluding large group discussion, I link these individual experiences to their broader structural context, and we consider how illness narratives assign blame and responsibility and how different healing systems might respond to the often divergent experiences and perspectives of patients, families, biomedical providers, and health-policy makers. Through grounding the analysis in concrete events and physically present protagonists (i.e., their classmates), I find that the illness narrative exercise nurtures cultural empathy and avoid the pitfalls of cultural and political stereotyping that frequently occur in macro level discussion of health-care policy (e.g., efforts to strength or repeal the Affordable Care Act, abortion access) and health promotion strategies (e.g., substance use, dieting/obesity reduction). That is to say, it is one thing to aggressively – and perhaps dismissively – criticize an abstract representation of all that you do not agree with, but it is quite another to speak to an actual, complex individual who experiences situations similar to yourself (i.e. illness and its accompanying emotional and physical distress). Such collective exercises in developing reflexivity and narrative humility lay the foundation for respectful and effective communication in health-care settings and may serve as a bridge for opening up discussion on other divisive issues.

The PSA Project. The course takes this process of developing cultural empathy and cross-cultural communication a step further in the course's centerpiece Public Service Announcement (PSA)

assignment. Here, students create a 60-second health promotion video following a scaffolded learning framework. Students first submit a two to three sentence description of their PSA topic and target audience at the end of the second week of classes. After revising their topic and target audience as necessary, students conduct background research and create an annotated bibliography from sources with diverse target audiences and discursive styles (i.e., peer reviewed articles, journalistic sources, non-profit and governmental websites, and health promotion campaigns). In the process, students are able to see the implicit and explicit biases of health-related research, interventions, and reporting. Students then have a month to create a storyboard for their PSA. To facilitate this process, we spend half of a class examining how to develop effective PSAs, including how to generate emotional and cognitive responses from target audience(s). This activity concludes with students creating and sharing a tweet (maximum 140 characters) that grabs their target audience and conveys their PSAs' main point. In these discussions, I highlight that successful PSAs need to move beyond the obvious (e.g., drunk driving is dangerous, eating huge amounts of sugar may have negative health outcomes) and should not assume that everyone in the target audience(s) shares the PSA creator's world view and health epistemologies.

Communicating Across Political and Epistemological Difference

All three of the pedagogies I have highlighted provide frameworks for addressing the significant emotions attached to health-related behaviors, health promotion campaigns and health-care systems. These passions are most dramatically displayed and examined in our final classroom activity, when we watch the PSAs in thematic groups of five to seven videos[1], followed by about 15 minutes of large-group discussion per video block. In the food, obesity and diet-related PSAs, for example, a divide usually emerges between students who advocate personal agency approaches (individuals need to eat better, parents need to control what their children eat, if you try you can succeed), and students who focus on changing structural factors linked to unhealthy eating and obesity (industrially processed foods, food deserts, GMO products). Building on our prior exploration of illness narratives, we use these disagreements as an entry point for examining how different nutrition and well-being messaging assigns personal blame and attempts to influence eating and exercise behaviors. These discussions highlight how the healthiness and acceptability of full/large bodies often varies among different racial/ethnic and cultural groups, distinctions that the biomedical model of obesity prevention does not usually consider.

The vaccine-related PSAs generate similarly polarized discussion, though as in the case of the food and diet videos, the divisions occur along different axes than the conservative-liberal divide that dominants national political discourse. These PSAs most often promote child vaccination by documenting the dangers of not achieving herd immunity in the general population. Yet not surprisingly given that Oregon is one of the states with the highest rate of school vaccine exemptions in the US, a significant minority of students question vaccine efficacy and vaccination promotion by government agencies and health professionals. These debates highlight the challenges of using scientific arguments – as well as determining the parameters of culturally competent health promotion – with individuals who self-consciously follow "alternative medicine" and/or health practices that do not accept the epistemological foundations of biomedicine. Here, I remind students of the anthropological concept of ontological politics (Langwick 2011) to facilitate their consideration of the complex questions raised by vaccination and alternative medicine. That is to say, decisions about what is "real," as well as who gets to make such determinations, are inherently political and position certain epistemologies – and cultures and political views – above others. With this theoretical map in hand, we explore how culturally competent health promoters (e.g., PSA

creators) might communicate between and across epistemologies in order to support their objectives (e.g. promote vaccination) while not suggesting that the beliefs and cultures of others (e.g., those who espouse non-biomedical or hybrid health belief systems) are misguided. These concrete examinations of ontological politics in action enable students to see that nearly everyone, including themselves, have complex worldviews that are not reducible to essentialized concepts of "culture" or one side of a essentialized dichotomy (conservative/liberal, rural/urban, white/Black, pro-life/pro-choice, religious/secular, poor/wealthy, etc.). This realization promotes the possibility of shifting the tone and content of communication across difference in the classroom and reducing some of the acrimony that characterizes current political discourse – and increasingly, everyday life – in the US.

A key lesson driven home by the PSA project is that uncertainty can lead to positive learning moments, including student's recognition that they experience significant emotional discomfort when presenting and discussing controversial issues with those who hold markedly different political positions and world views. This process is most dramatically illustrated in our discussions of sexual and reproductive health PSAs, and in particular, those focused on abortion, a perennially divisive issue in the US. For example, one video – perhaps more along the lines of a political ad than a traditional PSA, but nonetheless illustrative of these dynamics – presented late-term abortions as inhumane and called for viewers to contact the state legislature to end this practice. The visual content included the juxtaposition of ultrasound images of a healthy fetus and a dismembered fetus. Recognizing the likelihood that this video might provoke uncomfortable reactions, I embedded it in the middle of the block of sexual and reproductive health videos. Once we finished watching, students enthusiastically discussed all of the other videos, but there was not a single comment on the abortion-focused PSA. Seeking to break down the echo chamber – in this case, one of silence – I gently added, "does anyone have anything to say about the late-term abortion PSA? At least for me this was an intense PSA." Over the next ten minutes, students gradually opened up, with the first commentator saying that although the PSA seems to be "pro-life," it re-enforced her commitment to the "pro-choice" movement. The next discussant suggested that the purpose of the PSA may not have been to persuade pro-choice individuals to change their views, but to mobilize pro-life constituencies. A third argued that abortion is a matter of promoting women's health, while a fourth questioned whether there might not be a middle path and used a Roe v. Wade rational to suggest that abortion might be permitted in some situations but not others.

Interestingly, not a single student addressed the religious-ethical questions central to abortion debate in the US, such as fetal personhood or whether individuals or institutions have the right to not provide procedures they find immoral. My sense is that most students were aware of these contentious issues, but were reluctant to "open up the can of worms" and consider what culturally competent reproductive health promotion might look when communities and practitioners have divergent – if not contradictory— cultural practices and beliefs regarding sexuality, contraception, and when personhood begins. I was nonetheless pleased that after ten weeks of trying on anthropological theories and methods, the class was able to have a respectful discussion despite a certain level of discomfort on how to share their thoughts when they did not know how their classmates might respond. I credit this tentative yet ultimately successful entry in the emotionally unsettling terrain of epistemological uncertainly to the course's scaffolded explorations of cultural empathy and cross-cultural communication. In the future, I plan to more systemically explore emotion and cross-cultural communication in all my courses, including upper division anthropology seminars, as this model stimulates both critical and empathic understanding of contentious issues and political action we might take in response to them.

Conclusion

Like many medical anthropology courses, Culture, Health and Healing helps students learn that culture is best understood not as a fixed structure for making assumptions based on clients' race, ethnicity, religion or other defining characteristics, but rather a dynamic process situated in specific historical and political economic contexts. The course's acceptance of epistemological pluralism and attention to structural competence (Tsevat et al. 2015) provides students an anthropological framework for examining difference and power and for moving beyond an all too prevalent idea on both the left and the right that those who think differently are somehow immoral, unthinking, or deluded. This possibility is facilitated through the course's focus on health issues, where beliefs and practices often operate outside of the left/right dichotomy that pervades US political discourse.
In practice, breaking down the echo chamber is emotionally charged and often unsettling, particularly given the all too real consequences of the reactionary populist movements that have gained strength in the US and Europe in recent years. Yet, providing inter-personal learning opportunities to examine personal biases and diverse epistemologies is essential in supporting students' ability to successfully negotiate and impact these divisive landscapes, whatever their political orientations, once they leave the hopefully safe confines of the classroom. With its combination of relativism, cultural empathy and critical analysis, anthropological learning can play an important role in promoting dialogue – and ideally – positive social change across our current ideological divides.

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Notes

1. During the five years I have taught the course, the most common topics have been food and obesity (about 25% of PSAs), followed by mental health, substances and addiction, sexual and reproductive health, and risk management (15% each).