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## RELATIONAL TENSIONS IN ACADEMIC-COMMUNITY PARTNERSHIPS IN THE CULTURE-CENTERED APPROACH (CCA): NEGOTIATING COMMUNICATION IN CREATING SPACES FOR VOICES

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In this chapter, we engage with participatory reflections on a project that uses the culture-centered approach (CCA) (Airhihenbuwa, 1995; Dutta, 2008; Dutta & Basu, 2008) to develop culturally based, comparative effectiveness research summary guides (CERSGs) in two African American communities in two different counties of a Midwestern state. Funded by the Agency for Healthcare Research and Quality (AHRQ), this project works with two Midwestern counties that report large health disparities for African Americans, as well as large health disparities in the realm of cardiovascular disease. As a critique of dominant models of health communication, CCA seeks to foreground the voices of community members and their lived experiences and localized meanings of health, in demonstrating how dominant models of health communication have led to the silencing and erasure of such voices (Dutta-Bergman, 2004a, 2004b; Lupton, 1994). The goals of the CCA processes in this project are to create culturally centered CERSGs on heart disease that build on the participatory capacity of local communities to develop locally meaningful solutions, more specifically, to develop health-information capacities in the local communities. The CCA processes are driven toward transferring the spaces of power from the academic-community organization partnership to the more flexible, permeable elements of the community.

Connecting with the works of Barge (2004), Barge and Shockley-Zalabak (2008), Cheney (2008), Simpson and Seibold (2008), and the notion of “engaged scholarship,” we explore the

conceptualizations of the culture-centered approach as a model of participatory approach to research that represents a commitment to engagement with community members, the research practice, and the theoretical rooting of CCA within the discipline of Communication. Further, we demonstrate that by emphasizing what Barge (2004) called “reflexive practice,” CCA represents a fecund marriage of its theoretical lineage in critical scholarship and intellectual critique with the realities, uncertainties, and complexities of academic-community partnerships. The data for this paper come from the journal entries of the research team, as they engage with the community advisory board and the community in the initial stages of the grant. Finally, we present a grounded theory analysis of the data from the journal entries in order to articulate reflexive entry points on communicative processes described in CCA work.

### **CBPR and CCA: Participatory Approaches**

A growing number of communication scholars have expressed concern that the dominant approach to health communication focuses primarily on individual behavior change (Airhihenbuwa, 1995; Basu & Dutta, 2007; Dutta, 2008; Lupton, 1994). Embedded within this approach is cognitive or behavioral reasoning that looks to individual attitudes, beliefs, and behaviors to solve vital health problems (Basu & Dutta, 2007; Dutta & Zoller, 2008; Dutta-Bergman, 2004a, 2004b; Lupton, 1994; Yehya & Dutta, 2010). In employing this logic, the leading course of action to improve health disparities has been to strategically develop messages targeted at optimizing effectiveness, thus ultimately aiming to shape health decisions of marginalized populations (Dutta, 2008).

Health experts have begun to question the gaps between knowledge production in health-communication research and the translation of conventional research into interventions or transformative policies in favor of disadvantaged populations (AHRQ, 2009; Airhihenbuwa, 1995; Lupton, 1994; Viswanathan et al., 2004). This has led to the development of multiple theoretical frameworks that call for more participatory involvement in the entire health-communication research process. Thus, the following similar, yet fundamentally different orientations have emerged: (a) Community-Based Participatory Research (CBPR), and (b) the Culture-Centered Approach (CCA).

### **Theorizing the Purpose of Participation**

“Outside expert” research and interventionist approaches lack the ability to obtain sustainable, positive change, given the complexities of health problems and the corresponding location of power in the hands of academics at every point in the research process (Dutta, 2007; Lupton, 1994; Minkler & Wallerstein, 2003; Minkler, 2005). Thus, the concept of increased community participation has emerged as fundamentally crucial in health-communication processes. Though now viewed as essential to the entire communication process, the conceptualization of participation in the development of CBPR and CCA has spurred further dialogue that calls for more clearly identifiable definitions of such key terms. More importantly, the larger issue under scrutiny is the conceived and actual function of community participation as it informs research.

### **CBPR Participation as a Means to an End**

As defined by Israel, Schulz, Parker, and Becker (1998), centralizing participation in health-communication research sets forth principles of CBPR based on the following assumptions: (a) genuine partnership through colearning (academic and community partners learning from each other); (b) research efforts that include capacity building (in addition to conducting the research, there is a commitment to training community members in research); (c) provision of knowledge that benefits all partners; and (d) involvement of long-term commitments to effectively reduce disparities. The way in which participation is centralized in the implementation of CBPR is one that uncovers lay knowledge by enhancing researchers’ understanding of sensitive health issues particular to disadvantaged populations. It is through cultural sensitivity and humility that studies based in CBPR principles investigate unexplored contributors to health and social problems. This important information is often explored through local community needs assessments and formative survey research. For instance, the implementation of CBPR in Lee, Krause, and Goetchius (2003) led to a 69% response rate among a largely immigrant, and highly marginalized, hotel-room-cleaning population, thus yielding culturally sensitive data revealing the needs of this group. CBPR’s ultimate contribution to the health field is its ability to develop culturally appropriate measurement instruments

built upon the participation and responses of community members, therefore making projects more effective and efficient (Goodman et al., 1998; Viswanathan et al., 2004; Wallerstein & Bernstein, 1994).

Despite CBPR's logistical grounding in community participation, questions of purpose have also emerged (Dutta & Basnyat, 2008a, 2008b). Health-communication scholars with ontological commitments to the tenets of critical theory and subaltern studies continue to question the ways in which such orientations claim exclusion from the status quo. In centralizing participation as a means to an end, structural and cultural contexts are far removed from discussions of health issues within their local context. Dutta (2007) maintained that

Efforts of health promotion are typically based on the universal logic of scientific rationality, drawn upon individualistic assumptions about the constitution of health risks and hence are ignorant of cultural context, and are unresponsive to the social-cultural-economic contexts within which health experiences are located. (p. 305)

Though participation is placed at the forefront of CBPR, its system of reasoning still stems from that which dominates most health-communication research.

### **CCA Participation Under Interrogation**

The culture-centered approach (Airhihenbuwa, 1995; Dutta, 2008; Dutta & Basu, 2008; Dutta-Bergman, 2004a, 2004b; Ford & Yep, 2003) foregrounds the voices and lived experiences of cultural members in seeking to establish how traditional approaches to health-communication campaigns have contributed to the erasure of voices of marginalized communities, even in working to improve the health outcomes of such communities (Dutta, 2008). The notions of culture, structure, and agency represent three concepts central to the CCA. It is only through the interactions of these that a discursive opening can be found to "provide opportunities for co-constructing the voices of those who have traditionally been silenced" (Dutta, 2008, p. 5). In opposition to CBPR's usage of participation as a means to an end, the CCA takes participation and investigates its meaning within the process of seeking structural change while simultaneously finding relevance in the local narratives of health within a given community. Therefore, participation emerges in the CCA as meta-discourse about participatory proc-

esses. The CCA places emphasis on the need for investigating alternative entry points to interpreting health, and the ways in which ideas of health are understood in addition to those that are scientifically, clinically, or biomedically supported (Dutta, 2007, 2008; Dutta & Zoller, 2008). The CCA also centralizes participatory approaches as a pathway to understanding health meanings, and in doing so, continually turns the lens on the dominant structures. Constantly revisiting processes of reflexivity and performativity, it engages with the active, meaning-making processes through continual interaction with individuals as agentic entities, while interrogating the structural barriers that enable and constrain them in their everyday lives. Reflexivity, in the CCA, is ultimately connected to the project of emancipation that is embedded within it. This emancipatory impulse within the CCA is the legacy of its theoretical roots: in critical theory, postcolonial theory, and the subaltern studies literature. We now proceed to locate within the CCA some of the core tensions inherent in these traditions.

### **CCA and Critical Theory: Structure, Knowledge, and Power**

Culture-centered theories of health communication owe significant debts to the various strands of critical theory. In their interrogation of the nexus between knowledge and power, culture-centered theories reflect this core tension of Marxist critical theory. The relationship between knowledge and power has been the subject of many strands of critical theory, most of which are traced back to the work of Marx and Engels (Artz, Macek, & Cloud, 2006; Marx, Engels, & Tucker, 1978). CCA takes from these traditions a commitment to interrogate the interplay of knowledge production and power within the realm of global health communication, and is interested in exploring how conditions of economic marginalization are related to patterns of knowledge production within a health context (Dutta, 2008). For instance, in culture-centered work conducted amongst commercial sex workers in Kolkata, India, by Basu and Dutta (2009), it was found that the dominant knowledge claims about sex workers as passive and ignorant about matters of sexual health were debunked, and instead, the voices of these sex workers emerged as those of “experts,” given that their recommendations and understandings of what stood in the way of sex workers enacting effective sexual prevention behaviors was grounded materially within their lived experiences.

### **CCA and Subaltern Studies: Voice, Erasure, and Agency**

Originally emerging from the discipline of history, the subaltern studies collective represented scholars that were interested in the politics of historiography—or the writing of history (Guha, 1982). Subaltern studies scholarship begins with the notion that historiography is complicit in the erasure and silencing of voices that exist at the fringes of societies. Within a contemporary, health-communication context, the legacy of subaltern studies gives CCA the tools by which to analyze the current erasure of large populations of individuals from the construction of history and knowledge. For instance, Dutta-Bergman's (2004a, 2004b) work with the Santalis, a tribe that lives in the eastern part of India, explicated how the health choices made by the Santalis were largely contingent on what they earned everyday, given that most of them were daily wage laborers and needed to secure food for themselves and their children on an everyday basis. The author argued, then, that health experiences in marginalized, subaltern sectors must engage with issues of the structural barriers that impede access to health care and effective health options (Dutta-Bergman, 2004a). The concept of agency, as theorized in CCA, emerges in very direct ways from the subaltern studies literature, inasmuch as it attends to the individual enabling acts that subaltern communities engage in, in order to challenge the structural barriers that affect their daily lives. It is therefore with this emphasis on creating avenues for the participation of local communities in processes of change that the CCA turns the reflexive lens on the research process, continually interrogating the meanings that emerge in the negotiation of academic-community partnerships. Therefore, in engaging with processes of change in CCA, we seek to examine the following question: How does participation get conceptualized in the academic-community partnership?

### **Method**

#### **Data**

The data for this chapter are derived from the reflexive journal entries maintained by research team members through the life cycle of the project. This is accomplished through the initial setting up of a community advisory board, which codesigns and coconstructs the intensive, in-depth interviews and focus groups to be

conducted with community members. These in-depth interviews and focus groups become the foundations for organizing community coalitions, which further become avenues for working with the advisory board and the academic-community partnership in recruiting community members for communication capacity-building workshops, where the communication capacities of the community are built by community members through the development of communication strategies and tactical solutions.

Throughout the entire period of the project, the research team—comprised of one principle investigator (PI), three coinvestigators, one community leader from the partner community organization, and two community organizers—is required to maintain weekly reflexive entries as part of the process. These entries are maintained on a blog, giving the different project team members the opportunity to respond to each other's blogs, thus building a dialogue along the lines of CCA. This chapter is built on our analysis of the phase I of the blog entries maintained by the research team between August, 2010 and March, 2011. The blog entries resulted in 98 pages of blogging.

### **Data Analysis**

We conducted a grounded theory analysis of the research team blogs in order to develop insights into the participatory processes of CCA as articulated through the lens of the research team. Given the culture-centered theoretical lens applied in this project, we utilized a coconstructive grounded theory approach for data analysis, that emphasized the involvement of the participants in the meaning-making process. The data were analyzed using open, axial, and selective coding, as suggested by Charmaz (2000). Open coding identified the concepts as were explicit from the interviewees' responses. In the next step of axial coding, commonalities were taken from the open coding and related categories were formed. Finally, these categories were bound together to form theoretical integration (Strauss & Corbin, 1990).

### **Negotiating Communicative Spaces**

The two themes that emerged from the data analysis and constitute the key methodological questions for academic-community partnerships driven by the CCA are (a) heterogeneity of participatory directions, and (b) reflexivity as process. Our results depict



the contextually rooted, continually contested nature of academic-community partnerships, played out amidst the competing agendas of various academic and community stakeholders in the participatory processes of the CCA.

### **Heterogeneity of Participatory Directions**

Throughout the processes of engaging with the advisory boards, conducting the in-depth interviews, and articulating the directions of the project, the research team noted the heterogeneity of responses articulated by different participants from the communities in the two counties where we have been conducting our work. These multiple responses point toward the multiplicity of interpretive frames within the community, and the competing agendas, goals, and strategies articulated within these competing frames. Local meanings of heart health, comparative effectiveness research (CER), clinical decisions, medical practice, and experiences of physician-patient interactions are articulated within often contradictory understandings. At times, the locally situated agendas of change converged on some common threads. At other times, these agendas differed dramatically from each other. Even in instances where community members pointed toward a specific problem configuration, their notions of addressing the problem configuration differed dramatically. Here is an example of a tension in meaning-making noted by Latoya:

I've been thinking about several facets of the interview. How do we negotiate between conflicts in information? If one participant says one thing and another says something different or in opposition to the former, how do we as researchers negotiate these tensions. For instance, I noticed at last night's debriefing session, Ahmed noted how some participants noted that having a community advocate at the hospital would help the CERSG information be clearer and digested more easily. However, I remember another participant stating that this would not be a good idea as waiting to access doctors is already a job in itself. After bringing it up to the advisory board, it seemed they also agreed that having a heart health advocate will place a further burden on patients as well as the grant and community financially. So here we have conflicting ideas both from interview's participants and advisory board members. I wonder whose voice gets heard. Is it our job to choose whose voice is heard or should we try to make every voice heard? Also if our goals are to have all the voices of the community heard, then what are we to do when it comes time for the practical applications of these thoughts?

The contested nature of participation is foregrounded in this reflection. The subjective meaning articulated by Latoya through her interactions with a participant does not match up with the subjective meaning articulated by Ahmed through his interactions with some of the participants. Furthermore, the advisory board, which represents community members as well as staff members of the health coalition we have been working with, also had competing understandings of the role of the heart-health advocate and the costs that would be associated with having heart-health advocates at hospitals and clinics. It is against this backdrop, then, that the culture-centered processes of the project critically engage with the participatory frameworks of the project, raising questions about whose voice gets heard amidst these competing tensions, and what happens when such tensions arise. Of particular interest are the questions raised regarding the development of practical applications (such as having a heart-health advocate to explain the CERSGs) by working through the competing interpretations by different members of the communities, and by different stakeholder groups who are involved in the processes. For the research group, engaging in participatory dialogues with community members is constituted within working through the different and competing perspectives about meanings of health, heart health, experiences of interactions with physicians, and experiences in using evidence for making health decisions.

Along these lines, Ahmed noted the tensions in the politics of representation, as participatory spaces are turned into spaces for developing policies and specific interventions that are rooted in the voices of communities:

The politics of representation is perhaps the most difficult question to engage in with CCA work that is mainly concerned with making structural transformations. That communication is central to this structural transformation becomes apparent in the interviews. It is also through the politics of representation that CCA takes individual voices as legitimate entry points for theory building. However, the aggregation of individual stories as representative articulations of communities is the fundamental discursive shift that is embodied in the move from individual stories to policy articulations. Authenticity of the scholarship is negotiated precisely in the midst of this shift; from the individual to the community, at once recognizing the points of solidarity in articulating a community-based politics, and simultaneously continually acknowledging the fractures in the politics of representation that moves from individuals to communities. It is also amidst these tensions that I am

continually drawn to acknowledge the tensions in my desires to respond, to speak for, to become the voice of legitimacy for the community. This also is the key challenge: how do I lend my expert structures and the legitimacy that comes with these structures in solidarity with the voices in the community such that we speak together in working out a politics of change, a politics that envisions a just, equitable world.

The question that is raised by Ahmed here ties to the discursive move from individual subjectivity of the participant voices as narrated through the in-depth interviews to the act of aggregation in representing the voices of the community in the development of interventions and policies. When policy- and intervention-based decisions are made by the advisory group-research group partnership, such decisions are made amidst extrapolations of interpretations from individual stories to collective data at the aggregate level. Even as Ahmed spells out a politics of solidarity, inherent in this politics is the vital move from the individual stories shared by the community participants to specific solutions from the participant stories that are picked by the partnership of the research team and the advisory board, and are highlighted as entry points of change. In seeking to speak together with the communities in the context of cocreating a just and equitable world, Ahmed notes the tensions in working out what counts as the voices of the communities, privileging certain themes, and in that very process erasing and/or omitting other themes. The same thread plays out in the data transcription and analytic phase of the project, as the academic team works through the 150 hours of in-depth interview data to draw out specific themes at the aggregate level from the individual-level dialogues with community members.

Noting this tension in the participatory direction of the project as it moved from the individual subjectivities to an aggregated entry point for a politics of change, Vikram noted in his posting, titled "Aphorisms from the alcoves of a church":

Sitting in a recessed office at the back of a small church, our pastor-participant spoke about his struggles. Against the overwhelmed, unbothered medical system; against the systematic bureaucracies in the institutions around him. City Hall. The church. Corrupt officials; nepotistic pastors. A leaking roof; an aching back. Outside, the snow ravaged his rapidly decaying city: unplowed pavements, foreclosed houses; his struggle was his city's struggle—at the wrong end of a wantonly greedy system.

Harnessing the power of youth. He spoke passionately about the need to bring the youth back. Told us about his effort to start a youth center next to the church. A basketball court. Not as a way to 'exercise regularly to reduce heart disease risk', but more fundamentally, to build a youth-based community. To show kids a way out of the stress. The stress from living in the hood; from being poor and uninsured. To 'turn them around', as he said. Can there be a stronger example of health as negotiating structural barriers?

...He spoke about how he and his brother would talk about the medications they had each been prescribed, and between them, figuring out what was best for them; going and asking their doctors for more information, better medication, less side effects. They compared medications with each other, figured out what was common to their symptoms, keep challenging uncaring doctors only too eager to push pills on to poor patients. The brothers used a 'cultural barrier'; a family history of heart disease into an agentic resource; as a comparison group. Even a small fissure, like the  $n$  of 1 becoming an  $n$  of 2, can start the ball rolling, encouraging individuals to challenge the structures around them. What a story.

Worth noting in Vikram's reflection of the interview with one of the first participants in the in-depth interviewing element of the project is the articulation of the movement from the subjectivity of individual participation to the coconstruction of a collective narrative that may be mobilized in working toward change. Vikram points out that the story at the level of  $n$  equals 1 creates an entry point for building a politics of change constituted on the foundations of broader, community-specific data that are then used in working toward efforts of social change. As the in-depth interview engaged with the participant, it emerged as a site for storying the participant's understanding of his own life and his own relationship with his brother. It is through this relationship that the participant talked about making many of his health decisions, comparing notes with his brother, and arriving at solutions through the comparison of notes. Vikram notes how the brothers in this story re-storied the narrative of family history to create an alternative entry point where the relationship as brothers became a source for comparing between various treatment options. For Vikram, the movement from  $n$  equals 1 to  $n$  equals 2 constitutes the politics of change in CCA.

Contrary to the articulations of moving from the individual realms of subjectivity to the politics of aggregation that work in supporting each other and in creating an entry point for change,

the research team also noted the contradictions that emerge from the differences between localized articulations by community members as opposed to the articulations by the advisory board members, who are also from within the community. Arpita points out the following:

Throughout the CCA process there is constant discussion and awareness of the top down approach. As far as the research team is concerned, there have certainly been reflections on the recurring instances which arose during the advisory board meetings, where we as the research team would have to curb the urge to resort to a top down interaction in keeping with the CCA philosophy.

However, the same was not always the case during the feedback by the Advisory Board as regards what would and would not be a viable approach to take with the community members themselves. Now, as we move into the next level of interactions, it would certainly be a demonstration of how we have to be careful about the possibility of taking a top down approach, even when we get feedback from the people working in the community, if we do discover any significant differences between what the community members see as sustainable and workable solutions to certain heart health message communication practices, on the ground, in comparison to the feedback given by the board members, who, being in interaction with the community would still not necessarily be part of the community....It certainly puts in perspective the need to recruit not a convenient sample, but one that truly gives us data from a different perspective that maybe triangulates our prior data or takes us in a different direction that we may not have explored with the board.

Worth noting in Arpita's articulation is her perception of the gap between the voices of the advisory board and the voices of community members. Even as she notes the reflexivity of the research team in interrogating the top-down processes in order to create spaces for the advisory board, she also notes the power embodied in the advisory board and the top-down decisions that were being made by the advisory board, as it often took the position of being the voice of the community. In taking the position as representatives of the community, the advisory board was making certain decisions, and Arpita interrogates the top-down nature of these decisions as they relate to the politics of representation embedded in the notion of serving as a voice of the community. This is where Arpita also talks about the need for reflexivity at the level of the advisory board, particularly in instances where the board members took up the voice of the community to say things such as,

“community members would not understand this or that.” She further engages the question about the possible course of action when the articulations of community members do not really match with the articulations of the advisory board. Furthermore, worth noting in Arpita’s construction is the emphasis of the culture-centered approach on difference, pointing toward the need for recruiting community members in the next phase of the project (in-depth interviews) that provide alternative entry points, points of enunciation that attend to the dynamic and complex nature of meaning-making within communities. Highlighting this construction of difference as an entry point to change, Samiran similarly notes the following:

Lastly, given the reaction of the community members interviewed for the Gospel tour video, I am looking forward to seeing how many folks from the community grasp and imbibe the notion of the culture centered approach while analyzing these heart health messages for their community. This seems to be a fantastic opportunity to observe the fine balance between the materiality of working within a community, and simultaneously drawing out the possibilities of a solution based on listening and participation, which may not always be the most “sensible” approach initially, in the eyes of the community members themselves.

The voices of heart health at the gospel tour was a video-voice project that was undertaken by the research team at the request of an advisory group member, who headed the social equities initiative of the American Heart Association (AHA). The AHA historically conducts the gospel tour as a method for raising awareness about heart health through African American churches. During the video narratives with community members at the tour, the research team came across localized articulations by community members that did not match with the articulations of the advisory board. For example, some members of the advisory board in one of the interviews raised questions about the question, “What does heart health mean to you?” saying that the question would not work. Yet, when the question, “What does heart health mean to you?” was placed to community members at the gospel tour, they utilized the question to construct complex narratives of heart health. The research team would have scrapped this question had it not been for an alternative data point that had emerged through the prior interviews at the gospel tour, where community members responded positively and in an involved way to the question,

“What does heart health mean to you?” It is against this backdrop, then, that the research team continually worked back and forth about the methodological questions of decision-making, and the location of decision-making in the hands of the advisory board members as representatives of the community vis-à-vis placing decisions in the hands of individual participants from the community. At what points do acts of listening to advisory-board members as representatives of the community work in difference with acts of listening to other groups and subgroups within the community?

### Reflexivity as Process

Throughout our entries, the research team continually struggled with what it means to engage authentically with the two communities we were working with, and particularly as it relates to the decisions that were being taken by the research team through negotiations with the advisory board. The meaning of the term, *authenticity*, became a term for contestation, not only in terms of what would constitute authenticity, but also in terms of how does one act authentically in relationship to the community partners and advisory-board members. For example, building up to February 14, Angela suggested that we send out Valentine’s Day cards to community members to show that we care about them, and as a way to build a connection that takes the relationship beyond the impersonal domain of research. This, for Angela, was the way that the academic partner could demonstrate its care for the community partner and advisory-board members. She recalled how her mother always shared this story about this one research project that her mother participated in and would recall even after many years, because she received a card in the mail from the project director. To this suggestion, Vikram responded:

As I traverse through my personal struggles with CCA, with the meaning of critical pedagogy, I have some haunting questions. As an ‘owner’ of the method in a rather pragmatic sense, I benefit from it—I get published, I get taken seriously, I am ‘listened’ to in academic contexts, and so on. And at the same time, this ownership also demands of me an accountability; a responsibility to the standards that I proclaim. In that sense, this moment of ‘ownership’ is a daunting one; it means different things to me to be a student of CCA than it does to practice it. Perhaps this is just a displacement of my soon-to-be-on-the-market anxieties, but

questions of 'What commitments does culture-centered scholarship entail?' keep me occupied much more lately.

Why do I say all this? This is because the line between what constitutes solidarity and the touchy-feeliness of cultural sensitivity is always watermarked. Ergo, there needs to be a constant 'holding up to the sun' process; a reality check, a vigilant self-examination. The reason CCA can never be—dare I say must never be—a feel good exercise is precisely because the latter is the defining characteristic of its impostor: the 'ethics of care' as exemplified by culturally-sensitive global health communication.

What does it mean, then, for us to send an 'American Heart Month' celebration card to our community as a token of our appreciation? To clarify, this is not meant to be an ad hominem attack on either the person or the idea of sending cards out to people. Rather, this is an important point to deliberate because this is precisely the moment where the impostor puts on his mask. We've read all along that putting one's privileges on the table is an essential part of the CCA process. But what does that entail? What are its nuts and bolts?

I've spoken in earlier posts about my struggles to establish trust within our research community. As an outsider, I've learnt the hard way what it means to own up to one's privilege. I've found, to my great surprise, that it is not enough to belong to a group of trustworthy outsiders; the road to developing trust is always a solitary one. (I say this with profound humility—I don't necessarily think I can take as assumed the trust that the advisory board and our interview participants have in me). It is a process that takes time, reflection, swallowing a heck of a lot of one's own ego and notions of expertise. People who know me closely know how much I've thought about this process, and the journey that I have made even as I have come to know this community. I'm sure colleagues of mine who've been on this project with me, and who've joined this project after me, are, just like me, currently going through this journey, or will arrive at this moment in the future—this process always reminds me of standing at the immigration counter at US airports; and the relief that comes from getting your papers stamped.

Maybe this is too personal an impulse to be communicated, but I feel that sending 'American Heart Month' cards, well-meaning as the effort is, dilutes that moment and reverses that process in so many ways. I mean, as far as special months and occasions go, I don't think our efforts should point out that February is 'Black History month', and so we're doing that little bit extra for you this month. I wonder what it means to send an 'American Heart Month' card to an individual whose doctor is not bothered to even listen to what she has to say about her symptoms. Wouldn't it remind her of all the infrastructural differences between people who can actively seek out screenings during heart month, and those



who have to constantly change doctors so as to find one that actually gives a hoot? We're seeing from our interviews that dominant understandings of black communities are that they are passive, lazy, unbothered, ill-informed people. We're hearing their stories of actively struggling, making choices within what they have, coming together to help each other. Let's listen to these active voices harder.

What gets foregrounded in Vikram's articulation is his struggle with the development of authentic relationships, the development of trust with individual participants, the advisory board, and the community partners. He notes the politics of authenticity outlined in CCA that seeks to engage with listening as a way to transform existing power inequities. At the same time, he notes the tensions that emerge from the academic politics of CCA work, and the need to define and demarcate boundaries in order to etch out a space for the CCA work in the academic marketplace. Vikram locates the relationship of authenticity with community members amidst this question of authenticity that goes back and forth between a politics of change and a politics of bureaucratic functioning that operates upon the needs of the marketplace.

For Vikram, the sending out of the Valentine's Day cards to the community members amounts to the superficial touchy-feeliness of cultural sensitivity, an inauthentic move that superficially attempts to craft a relationship of solidarity without really listening to the active voices of community members and the stories of their struggles in securing access to health. Without attending to the structural issues of access, sending out cards are reminders of the inequities that constitute the inaccess to health. Vikram feels that carving out the relationship of authenticity with community members is one of sincere listening, one that attends to the struggles of inequities and injustices that are articulated by the community members, bringing these struggles to the forefront. Whereas Angela thought that sending out the cards would serve as a marker of building an authentic relationship with community members, and as an indicator of a relationship that aspired to move beyond the traditional relationship of researcher and researched, Vikram resisted the idea based on the notion that a card is superficial and does not really create the scope for building a relationship of authenticity that is sensitized to the inequities written into the differential positions of power occupied by the research team and the community partners.

Latoya, herself an African American who grew up in a context very similar to one of the communities in this project, responds to Vikram's notion of authenticity through the acknowledgement of the struggles articulated by community members:

Every time someone says the African American community members said this or that, I become physically tense and defensive as if any and everything someone says about the African American community applies or represents my thoughts, goals, and experiences. I know that everyone has different experiences and understandings of their life, but it is quite difficult for me to suppress these feelings. Notice in *Vikram's* blog earlier, he states (about the voices of African Americans interviewed so far) that "We're hearing their stories of actively struggling, making choices within what they have, coming together to help each other." My gut response was, "oh my goodness, here we go again with the rhetoric that still somehow addresses us as struggling, always trying to do better, to be better...simply always struggling." Now I know that *Vikram* never meant it in this way, to further marginalize the group as "always struggling" or which some would say, never reaching a level of contentment or solace, but it's so difficult not to respond to this. It has been my experience that the dominant understanding of the African American experience is one in which we are portrayed as lazy (and all the other adjectives *Vikram* pointed out), but another way that African Americans have been talked about has been from the perspective of a group of people always struggling against the structures that bound them, especially in media.

This perspective has also been a more acceptable view as it doesn't demonize African Americans and their perceived unwillingness to carry their own weight in the name of rugged individualism. If you think about it, this rhetoric has been around since slavery, similar to other forms of depictions such as the lazy African American. Let's think about it, if you've ever taken an African American studies course or any course that talks about slavery, you will learn how African Americans used old Negro spiritual songs to aid in getting the message out about fleeing plantations. Additionally, you found out that these songs helped in the struggle of African Americans, allowing them an outlet to bear the daily hardships of their lives. Moving in time, you'll also see many discussions of African Americans during the civil rights movement, when the "struggle" turns towards their fight for equal rights. I'm not saying that is it wrong to state that people are actively struggling with the structures as we all do it every day, but I just hope that we as researchers are careful that we do not further marginalize the group by reintroducing another interpretation of the African American experience, even if it may be true. Note here I do think it is true that African Americans in our interviews spoke about actively struggling and making "do" with what they have, but I just want to bring up that even in doing this, in claiming this ex-

perience, we walk a fine line of placing another dominant understanding of African Americans in to the dialogic spaces of heart health discussions. One which has been used before and one which may quickly become trite.

What Vikram sees as the focal point for a politics of authenticity rooted in the everyday struggles of the African American community members who share with us the stories of their pains and struggles in the context of securing access to health resources, appears as a politics of aggregation based on patronizing stereotypes to Latoya. To Vikram, the reality of the in-depth interviews was articulated through the stories of pain and suffering in the context of defining meanings of health. Vikram arrived at his narratives through the processes of coconstructions in the in-depth interviews. Latoya, however, notes the problem in moving from the individual stories of pain and suffering to aggregate responses that sought to represent the narratives of the African American community in terms of struggles. Note here the tension Latoya feels as herself being a member of the community, making a discursive move to take ownership of her own identity in the context of the project and in the context of her relationship with the community. To Latoya's response, Ahmed notes during a one-on-one conversation with Latoya:

You make a really good point about the importance of being careful about how and how far we are extrapolating the stories that emerge from the in-depth interviews. You encourage each of us to be mindful of how far we extrapolate? In this process of extrapolation though *Latoya*, the question also worth asking is: How do you make the transition from being the researcher to talking about the community as "we," based on the assumption that you are a member of the community? So my interest is also in this personal transition for you, from being a researcher to being one of the community. So now you live in one of these communities, so you can claim perhaps that you are a resident and hence a community partner. And yet, you are also a member of the research team, the one who is sitting amidst the privileges of the dominant structure and getting to set up the rules of the game. So what does this mean in terms of your own responses when you hear these stories?

Reflexivity is not only embedded in the questioning of one's role and position within the academic-community partnership, but also in the questioning of the specific questions that are asked in the in-depth interviews, the reflections on these questions as the in-

terviews unfold, and the flexible adjustment of questions based on the articulations of community members. Vikram had the following to say about observing an in-depth interview conducted by Ahmed:

When he asked him what health meant to him, he spoke from his rich experience....He was detailed, confident and clear in his responses. However, when we asked him a 'fact' question; what appeared to be a typological question; a 'how many kinds of...are there' question, he felt distinctly uncomfortable. It became a moment where we 'experts' were unwittingly testing his knowledge of heart disease. When the question was skillfully rephrased as a 'meaning' question, back to his normal eloquence.

So much of CCA hinges on little choices we make. Rhetorical, nonverbal, gestural, lexical. Ahmed, I saw you get that moment of discomfort and react to that. I wonder if you were consciously aware of that; and remember that now. How much vigilance is hyper vigilance?

Vikram's articulation of the in-depth interviewing process brings attention to the constant vigilance at the dialogic moments of the in-depth interviews, where listening to the stories of participants also continually calls for "working on the self" for the interviewer, being aware of the gaps and fissures in the questions she/he asks, the foreclosures that are brought about by particular phrasing of questions, and the need to continually revisit the questions at the very sites of the in-depth interviews. Worth noting here is the gap between the in-depth interview protocol developed by the academic-community partnership and the advisory board, and the phrasing of the question that creates an entry point for a conversation. Whereas Vikram observed that asking the fact-based question about the different types of heart disease led the interviewee to feel uncomfortable, the rephrasing of the question into a question of meaning made him feel at ease again. Vikram discusses these as the little choices we make, and yet these little choices we make are situated amidst the continual reflexivity of the research team throughout the processes of the in-depth interviews.

### **Conclusion**

The two key themes that emerge from our engagement with the reflexive processes that the research team was going through are

constituted around the contingent and contradictory nature of communities, and the relationships between community and academic partners. The academic-community partnership in our culture-centered model is situated amidst multilayered relationships with the community, advisory board, and the minority-health coalition. At each of these interfaces of communication between the academic entity and the community constituents, tensions arise in the articulation and representation of needs, and in the interrogations of the terrains of representation. Emphasizing the Subaltern Studies roots of CCA, our reflexive entries continually engage with the erasures in our participatory processes, interrogating the ways in which these processes, at multiple interfaces—from the academic-organization partnership, to the partnership with the advisory board, to the partnership with community members—are continually constituted at entry points of erasure. Even as the participatory processes of CCA seek to engage with local community voices, they are intrinsically tied to the erasures of these voices through specific elements of the methodologies. It is in the context of such erasures that our reflexive journal entries point toward the “work on the self” through which CCA seeks to create entry points for listening to voices of community members from the margins of dominant structures.

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# REDUCING HEALTH DISPARITIES

## Communication Interventions

Edited by Mohan J. Dutta  
and Gary L. Kreps

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