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Narratives of Stress in Health Meanings of African Americans in Lake County, Indiana

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ABSTRACT
Across the life course, African Americans bear an unequal burden of disease compared to other racial groups. In spite of the widespread acknowledgment of racial health disparities, the voices of African Americans, their articulations of health and their local etiologies of health disparities are limited. In this article, we highlight the important role of communication scholarship to understand the everyday enactment of health disparities. Drawing upon the culture-centered approach (CCA) to co-construct narratives of health with African Americans residents of Lake County, Indiana, we explore the presence of stress in the everyday narratives of health. These narratives voice the social and structural sources of stress, and articulate resistive coping strategies embedded in relationship to structures.

A substantive body of literature documents the clinical, epidemiological, and sociological aspects of race-based health disparities (Adler & Stewart, 2010; Kawachi, Daniels, & Robinson, 2005; Lu, Hajifathalian, Ezzati, Rimm, & Danaei, 2014; Williams, 1999). However, the corpus of work that focuses on how communication processes are implicated in the production and constitution of such disparities is more limited. Communication scholarship often focuses on post-positivist message dissemination strategies emphasizing culturally sensitive message production processes (see for instance the seminal piece on health communication addressing health disparities by Dutta, 2007; Freimuth & Quinn, 2004 and the criticism of this post-positivist approach offered by). Other communication research on health disparities has focused on the building of communication technology infrastructures to address the intersections between digital divide and health disparities (Kreps, 2006), the construction of health disparities in the mass media (Niederdeppe, Bigman, Gonzales, & Gollust, 2013), public resistance to messages (about the causes) of health disparities (Gollust & Cappella, 2014), and the association between health inequalities and race-related communicative inequalities within the US healthcare system (Kreps, 2006). Not much attention has been paid to a) health articulations/narratives of communities that bear the brunt of these disparities and b) the interpretive etiological frames used to talk about disparities by members of such communities. In this article, drawing upon the culture-centered approach (CCA), we attend to the local constructions of health meanings in an underserved community, and highlight the role of interpretations within the context of health disparities.

This article employs the CCA to health communication (Airhihenbuwa, 1995; Dutta, 2008) to understand the everyday experiences of health among African Americans¹ in Lake County, an underserved region in Indiana characterized by high mortality and morbidity rates, as well as high infant mortality and morbidity rates for African Americans (Indiana Minority Health Coalition, 2011). Grounded in the principles of dialogic communication (Bakhtin, 2010), the CCA engages in co-construction with communities at the margins to foreground their voices in the discursive spaces of policy-making and program planning (Dutta, 2004).

A key argument of the CCA is that communicative marginalization often works hand-in-hand with material deprivation, and to this end, co-constructing narratives of health in collaboration with marginalized communities acts as an entry point for transforming unequal structures (Dutta, 2008). Therefore, the CCA begins with an emphasis on legitimating local, culturally rooted theories as entry points to conceptualizing health and developing health solutions through community participation from the ground up. In this sense, structural transformation is achieved first and foremost through the presence of the hitherto erased voices of communities at the margins, participating in processes of dialogic co-construction (Bakhtin, 2010). It is this emphasis on attending to the erased, silenced, absent voices that connects the CCA to the study of health disparities.

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¹Throughout this article, we have used the term “African American” instead of “Black,” except for those instances where the latter term is used in a direct quote. While we realize that the terms are not perfectly interchangeable, we use the term after consulting with our community advisory board in Lake County, Indiana.

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Race, Health Disparities, and the CCA

In the USA, African Americans systematically experience an array of health disparities, reflected in the form of various negative health outcomes ranging from disproportionately higher mortality and morbidity rates, to greater disease burdens borne by African Americans as compared to other races (Barr, 2008; Williams & Collins, 1995). The age-adjusted mortality rate for African Americans is consistently higher than the age-adjusted mortality rates for all other racial and ethnic groups (Centers for Disease Control and Prevention (CDC), 2013; Mensah, Mokdad, Ford, Greenlund, & Croft, 2005). Across the life course, African Americans experience disparate proportions of health risks (CDC, 2013). Otten, Teutsch, Williamson, and Marks (1990) note that despite adjusting for risk factors and family income, disparities in excessive mortality between African Americans and Whites in the USA exist due to unexplained causes. Smedley, Stith, and Nelson (2001) analyzed clinical encounters of minorities, which are fraught with complexities, and observed that pre-existing stereotyping and biases contributed to the lack of ability to meet minority needs. In addition, they observed that “financial and institutional arrangements of health systems, as well as the legal, regulatory, and policy environment in which they operate, may have disparate and negative effects on minorities’ ability to attain quality care” (p. 1).

The patterns of health disparities experienced by African Americans at the national level are replicated in Indiana, where Lake County is located (Indiana State Department of Health (ISDH), 2003). According to the 2002 United Health Foundation State Health Rankings, Indiana was ranked 40th in terms of Years of Potential Life Lost (YPLL) in 2002, with “Blacks or African Americans suffering 15,120 potential years lost per 100,000 population before age 75” (ISDH, 2003, p. ES1), a loss that is twice as much as the White population in Indiana. Comparing Indiana mortality rates to the national mortality rates for African Americans, the 2003 Indiana Minority Health Plan noted that the state’s rates are higher for African Americans as compared to the national rates for African Americans (Indiana State Department of Health, 2003). The differences in health outcomes for Indiana African Americans compared to other races played out throughout the life course. Further, along the lines of the national data, the leading health risks for African Americans in Indiana were heart disease, cancer, stroke, asthma, diabetes, and HIV/AIDS.

Heart Disease and Disparities

Cardiovascular heart disease (CHD) provides an illustrative example of the disparities experienced by African American populations. Nearly one-third of the mortality difference between African Americans and Whites can be attributed to CHD and diabetes (Powers et al., 2009). Hypertension in itself may be responsible for almost half of the CHD mortality disparity between Whites and African Americans (Davis, Vinci, Okwuosa, Chase, & Huang, 2007). As compared to their White counterparts, African Americans in general experience disparities in the presence of vascular risk factors, access to quality coronary disease procedures, experiences with healthcare professionals, and mortality for CHD and heart failure (Clark et al., 2001; Davis et al., 2007).

In a comprehensive study by Mensah et al. (2005), the investigators noted the existence of disparities in all the known risk factors for cardiovascular diseases. Hypertension prevalence was found to be highest among African American participants (among men and women) as compared to any other racial group. Further, cardiovascular mortality at all ages was the highest in African Americans. A recent study by Lu et al. (2014) investigated racial disparities in CHD by estimating a 10-year risk distribution of CHD mortality based on five leading modifiable risk factors. The authors found that African American participants faced higher CHD mortality risk than White participants across the board. Moreover, the racial disparities in CHD mortality risk were larger for high-risk subgroups compared to those at low or moderate risk, meaning that the higher the risk for CHD, the wider the racial disparities between African American and White patients.

Stress, Health, and Disparities

While the era of outright discrimination toward African Americans might be behind us, more subtle, covert, everyday forms of discrimination are an unfortunate reality for most African Americans today. Several scholars have studied the impact of such discrimination (and the ensuing stress) on physical and mental health outcomes. It is outside the scope of this article to provide a comprehensive picture of this research. However, some extensive systematic reviews that have been conducted in this area (Mays, Cochran, & Barnes, 2007; Thoits, 2010; Williams & Mohammed, 2009) allow us to make some broad observations. While the relationship between discrimination-based stressors and overall health outcomes has been systematically established, there is now increasing evidence about the association of discrimination stress and specific physical health outcomes (Pascoe & Smart Richman, 2009). Further, among African Americans, the negative health impact of discrimination was not limited to personal discriminatory experiences. Even perceived discrimination was found to have significant impact on mental and physical health outcomes (Pascoe & Smart Richman, 2009; Williams & Mohammed, 2009).

More significantly, a growing body of research points to the relationship between the stress caused by racial discrimination (experienced or perceived) and specific cardiovascular outcomes like systolic and diastolic blood pressure levels (Brondolo et al., 2008). While some studies have reported inverse or counterintuitive associations between discrimination and cardiovascular health, Williams and Mohammed (2009) argue that inaccurate/inadequate measures of discrimination might be the reason behind such findings.

Overall, the impact of racism on (heart) health may be more adequately explained through more recent biosocial models of health disparities, like McEwan’s concept of “allostatic load” (Mays et al., 2007), which emphasizes interaction between cognitive/affective factors and physiological responses. For individuals that are exposed to chronic stress, the prolonged “fight or flight” response may cause significant
“weathering” of the body’s ability to respond to stress in the long run. In addition, the picture of the comparative health outcomes for African Americans and Caucasians in Indiana (as it is nationally), while bleak, is confounded by the complex relationship between race and social class (as measured by socioeconomic status (SES)) and other demographic factors (Kawachi et al., 2005), which we attend to in the next section.

**Race, Class, or the Interaction**

There have been numerous interpretations, mechanisms, and pathways delineating the role of race in health disparities (Adler & Rehkopf, 2008; Williams & Mohammed, 2009). Race has been constructed as a “biologically meaningful category” adopting the notion of genetic susceptibility to disease; race has also been understood as a “proxy” for class, holding socioeconomic stratification responsible for social disparities, reflected in health disparities (Hayward, Miles, Crimmins, & Yang, 2000); and finally, the role of race in health disparities has been viewed by others as neither a biological category nor a proxy for class, but as a distinct construct (that works akin to caste), taking into account the interaction of both race and class in determining the health disparities to which patients are subject (Kawachi et al., 2005). Some researchers (Adler & Newman, 2002; Isaacs & Schroeder, 2004; Meyers, 2008; Williams & Collins, 1995) have outlined parameters of SES such as standards of education, income, occupation, and wealth as the most important determinants of racial and ethnic health disparities. Further, it has also been demonstrated that health differences between socioeconomic groups are often greater than differences between racial groups (Isaacs & Schroeder, 2004; Kawachi et al., 2005).

However, a majority of studies report that measured disparities between races are reduced, but not eliminated after controlling for SES (Baldwin, 2003; Kawachi et al., 2005). According to Smedley et al. (2001), racial and ethnic disparities in health care continue to exist irrespective of the similarities in the income, age, insurance status, and severity of conditions of patients, thus singling out racial and ethnic discrimination as factors which continue to exist despite controlling for the other aforementioned factors. Such disparities are situated within the broader context of the African American socioeconomic–cultural fabric, contributing to discrimination within sociocultural structures, local organizations and institutions, and the healthcare system (including providers, patients, and healthcare plan managers as discriminatory subsystems within the larger organizations of power).

The health of ethnic and racial minorities is affected disproportionately by health care conditions in comparison to the health of their White counterparts (Baldwin, 2003). The most often cited reasons for this include SES, access to health care, lack of health insurance (Collins, Hall, & Neuhaus, 1999), insufficient transportation to access health services, low income geographic location (not enough providers in an area), and unaffordable cost of services (Collins et al., 1999). Other reasons noted for such disparities include the health behaviors of minority groups, which might not adhere to mainstream ideals, environmental factors, and direct and indirect manifestations of discrimination (Williams, 1999).

Although the research on health disparities documents the disenfranchisement experienced by African Americans (as racialized and/or classed subjects), not much research has focused specifically on the voices of African Americans and the interpretive frames they employ to interpret their poor health status (Pascoe & Richman, 2009). By focusing on local etiologies, experiences, and health attributions, the CCA disrupts the communicative erasure experienced by marginalized communities, developing locally grounded, emic theoretical frameworks emerging from the participation of subaltern voices in the discursive space (Basu & Dutta, 2009). CCAs do not presuppose the etiology of health disparities as located within race, class, or in their interaction; rather, the CCA arrives at the meanings of disparities for community members, as seen through participants’ narratives.

**CCA to Health Disparities**

The CCA is especially relevant to studying health disparities for two principal reasons: a) as a theory based in communication, CCA emphasizes how marginalized groups make meanings around health and b) this emphasis on local, cultural meanings provides a platform to connect the material causes of health disparities (structures) to the everyday enactment of decisions in negotiating these disparities (agency), using interpretive etiological frames voiced by communities at the margins (Dutta, 2008). The emergence of meanings as the focal point of scholarship grounded in the CCA interrupts the message-based framework of psychologically driven communication studies that solely emphasize individual behavior change (Dutta, 2007). The CCA emphasizes the centrality of meaning in communication about health, attending to the ways in which communities at the margins interpret health, configure health problems, and develop locally derived solutions to address these contextually situated problems (Airhihenbuwa, 1995; Dutta, 2008). Meanings of health are constituted at the intersections of culture, structure, and agency, and are voiced through dialogues with marginalized communities. Culture, referring to the local contexts, includes values, beliefs, rituals, norms, and expectations that make up the dynamic web of meaning making through which cultural participants negotiate their everyday lives. Culture is understood as dynamic and is continually in movement, suggesting that cultural norms and values are negotiated through everyday human action that is contextually embedded within structures. This emphasis on culture is especially relevant to studying health disparities, given that communication processes lie at the core of a group’s cultural formulations of health. As opposed to the dominant framework of health communication where culture is deployed as an instrument for changing the behaviors of communities at the margins, in the CCA, culture informs communication as a process of meaning making at the margins that disrupts taken-for-granted and universalistic assumptions of the mainstream (Dutta, 2008).

Structures refer to the institutional landscapes and/or systems of organizing within which patterns of resource distribution are determined (Giddens, 2007). In as much as they inhere within the economic configurations that affect the distribution of societal power, structures determine access and (in)access to resources. In the context of health, structures include points of access (or (in)access) to food resources, healthcare, education,
opportunities of work, etc. that in turn shape the everyday lived experiences of local community members. *Agency*, referring to the local participatory capacities of communities at the margins, attends to the ability of cultural members to make sense of structures, to negotiate them, and to seek to transform them (Dutta, 2004). *Agency* is reflective of the active roles taken by community members in negotiating their everyday lived experiences. Culture, structure, and agency intersect to constitute the frames within which meanings of health are negotiated and actions are configured. This three-way relationship between these components makes *CCA* especially salient for examining the communicative aspects of health disparities.

In this article, we build on a body of literature that has employed principles of *CCA* to a) document health disparities in a variety of global contexts and b) employ local cultural narratives of health to juxtapose the everyday enactment of health voiced by marginalized communities within the structural contexts of health disparities. For instance, Dutta, Anaele, and Jones (2013) adopted the *CCA* to understand food insecurity in two communities dispersed across the globe, demonstrating that local, emergent meanings of hunger (documented in community members’ voices, narratives, and photographs) were crucial in drawing connections between the stigma associated with food insecurity (culture) and the actionable policy recommendations (structure). Basu and Dutta (2009) reported how localized, bottom-up framing of health problems among marginalized sex worker collectives in India was associated with identification and successful targeting of structural barriers to health. Extending the questions asked in this body of work, in this article, we ask:

Research Question: How do the narratives of African Americans in Lake County, Indiana reflect the everyday enactment of health disparities?

**Method**

The data for this article are drawn from 32 in-depth interviews we conducted with African American community members in Lake County, as part of an *Agency for Health Care Research and Quality* (AHRQ)-funded project on health information capacity building in two African American communities (Dutta, Collins, Hines, Roberson, & Okoror, 2010). We are a team of academics and community organizers who came together under the umbrella of “Communities and Universities Addressing Health Disparities” (CUAHD).

A community advisory board—whose members were selected by our community partner organization, the Indiana Minority Health Coalition (IMHC)—acted as our primary gatekeeper to the community. In addition, we also worked with local community organizers who were collaboratively recruited by the academic and community partners, and were employed as staff on the project. We regarded the advisory board members and organizers as community experts, who helped us in recruiting interview participants, suggested appropriate compensation amounts, and made specific changes to our interview and discussion guides and other material, so as to tailor it for the specific communicative expectations of community members. While some members of our research team were full-time residents of Lake County, the entire research team—regardless of residence—spent extensive time in the community, facilitating workshops with the community advisory board, conducting interviews, attending town hall meetings, attending health screenings, attending state-wide health disparities initiatives, etc.

**Context: Lake County**

Nearly 25% of Lake County residents are African American, meaning that the Northwest Indiana County has the highest concentration of African Americans in the state (Indiana Minority Health Coalition, 2011). From 1990 to 2010, the population of Lake County increased by 4%, with an increase in the population of Hispanic/Latino and African Americans, and a decrease in the population of Whites. As of 2010, the total population was 496,005 consisting mainly Blacks (25%) and Hispanic/Latino (16.7%) (US Census Bureau, 1990, 2000, and 2005–2009). Lake County has been designated as medically underserved because of the shortage of medical personnel and the limited availability of services for the population in need in the area (Indiana Minority Health Coalition, 2011). The categorization of the county as medically underserved also connotes that the county receives significantly less treatment and attention for disease conditions compared to other counties in the state. Further, the county is characterized by high levels of poverty among African Americans as well as high infant mortality.

Lake County is ranked low in the 2011 State health ranking (47–84 out of 92) for various health outcomes (University of Wisconsin Population Health Institute, 2011). The State health ranking provides vital information about the health of the population in each county and serves as a basis for determining the morbidity and mortality among a population in geographical locations. The ranking in Indiana looked at 92 counties in the state and the scores ranged from 1 to 92, where rank 1 represented the best and 92 represented the worst-case scenarios. Unemployment among African Americans in Lake County was 15.8%, whereas the corresponding rate was 8.8% among Hispanic/Latinos and 6.9% for Whites. This ranking report also mentioned that 32.2% of African Americans in Lake County were living below the poverty line, far larger a proportion in comparison to other racial groups. The median household income among African American families in Lake County in 2010 was US$29,428, whereas for Whites, the median household income was US $56,844 (Indiana Minority Health Coalition, 2011).

Typically, counties with good measures have higher populations with education and good jobs, whereas counties with poor or lower outcomes are predominantly inhabited by minorities, with lower educational levels and lower incomes. According to the IMHC 2011 report cited earlier, 19.6% of the African American population in Lake County is uninsured.

**Recruitment**

The participants for the interviews were recruited by the community partner, in collaboration with the advisory board and community organizers, who often suggested potential
names and selection criteria. Using theoretical sampling that had guided the development of the screening criteria, the community organizer activated interpersonal networks in local churches as well as placed recruiting advertisements in various outlets in the community (churches, community organizations, local clinics, barber shops, and shopping malls). The community organizer worked with the research team to schedule the interviews. Given the time required for the interviews, participants were offered US$50 for completing the interview. The advisory board, research team, and community organization collaboratively determined this as the appropriate level of payment.

**Data Collection**

The in-depth interviews, conducted over a span of a year, were embedded within an overarching ethnography of participatory processes in a culturally centered intervention that involved a diverse range of methods including focus groups, community workshops, advisory group discussions, photo-voice, and community-wide town hall meetings. An interview guide was developed through a co-constructive process involving our community partner, the advisory board, community organizers, and research team members. The interview guide focused on understanding localized meanings of health, starting with general questions on meanings of health, and proceeding into semi-structured probes that delved deeper into the specific meanings and interpretations of health for African Americans within the community. A blanket human subjects approval (with Purdue University) had already been obtained for the larger funded project, which was then modified to include the co-constructed interview guide.

As mentioned earlier, participants were recruited through the recommendations of the community organizer and the advisory board. The interviews ranged from 1 to 2.5 hours, and were conducted in a dedicated, private room in the community partner’s office. After the community organizer introduced a potential participant to the interviewer (academic research team members), we sought to obtain informed consent through the presentation of the Institutional Review Board (IRB) consent form and a brief rationale for the interview. Participants were asked if they would prefer the consent form to be read/explained to them, and once they signed the form, the interview started with initial open-ended questions about meanings of health.

**Data Analysis**

The 32 in-depth interviews resulted in approximately 130 hours of taped conversation, and approximately 1,000 single-spaced pages of interview transcripts. In order to ensure immediacy and quality of the data, interviews were transcribed by the same research team members who conducted the interviews. Team members also participated in writing memos after conducting each interview and during transcription. We used these memos as spaces for reflexive dialogue and for refining the interview protocols in subsequent interviews. One of the hallmarks of our data collection/analysis process was the constant fine-tuning of the interview guides through regular dialogues that took place between academic partners and community partners, organizers, and advisory board members. We continued to share our analysis with our advisory board members even as we were conducting the interviews, thus fine-tuning the questions, contributing additional questions, and modifying the interview protocol.

We started the data analysis by developing open codes that reflected the themes at the level of each sentence. We shared the open codes with our advisory board members and made sense of them through conversations. These conversations then also served as guiding posts for the subsequent interviews we were conducting throughout the cycle of the project. Based on the open codes that we gleaned from the data, we developed axial codes. These axial codes may be conceptualized as broader buckets into which the different open codes could be categorized. This process of placing different codes into categories and coming up with category names and definitions was carried out by the partnership between the academic team, the community organizers, as well as the advisory board members. Finally, once the axial codes were developed, advisory board members worked collaboratively to propose selective codes that connected the various axial codes into concept maps, offering a community-derived framework for interpreting health. The codes were also brought back to articulate their inputs.

The framework thus developed was shared in a community-wide town hall meeting under the banner of the Northwest Indiana Health Disparities Initiative that brought together African American community members, community leaders, as well as representatives of various local health organizations. In this sense, the data analysis was multi-layered, working through various levels of conversations with the community. Foregrounding the local context of Lake County, the meanings of health that emerged through our co-constructions in the in-depth interviews converged on the role of stress as an organizing frame for interpreting health.

**Stress in African American Narratives of Health**

Participants’ narratives emphasized health as the absence of stress, noting the various ways in which stress was manifest on the bodies of African Americans living in Lake County. In understanding their lived experiences with stress, community members pointed toward the various structural factors that influence the levels of stress they feel. Further, in discussing stress as a threat to health, they discussed how they negotiated everyday stressors by adapting to them, ignoring them, and simultaneously developing mechanisms to overcome them.

**Stress and the Individual Body**

Community members narrated the effects of stress showing on the body as a way to communicate the absence of health. Every day, immediate physical experiences of stress on the body served as the frame through which participants came to understand stress and its relationship with health. Consider this narrative account co-constructed by Jacinda.²

²All names used in this section have been changed to preserve participant anonymity.
Jacinda: Well stress releases chemicals in the body, we know that our bodies are nothing but a big ball of chemical reaction and everybody’s body is different you know what we put in might affect me differently then it affects you. When we allow a lot of negative energy to come in, then what happens you start having negative things happening in your stomach you know where the acids get all upset I mean I’m just putting it in a broad sense and I might not be as physiology correct, but I know that there are negative things happen when you’re under stress and they show in the body.

Author 2: So can you detect stress on your body?

Jacinda: Oh yeah, most definitely well for one thing it’s hard for me to sleep that’s the first thing and I also notice my heart rate. I notice my blood pressure goes up when I’m under stress because until the lord heals me, I do deal with diabetes. When I’m under stress, I experience an increased occurrence of numbness and things like that. My husband passed back in 2007 and I was numb from my finger tips to my elbows for about 4 weeks and once I got some things together, I moved back home with my parents for a few months. That numbness just disappeared because I was getting some rest. It was because I was relieving some of the stress factors in my life at the time and it showed I mean physically okay and I felt relief as the stress left.

Here, through the sharing of her experience with her husband’s death, Jacinda narrates her story of stress as a series of physical symptoms (numbness, heart rate, etc.). This physical experience of stress is connected to her psychological experience of loss. Participants regularly connected the emotional/psychological effects of loss, discrimination and other non-physical events to the physical manifestations of stress on the body. Further, stress was understood as a threat to physical health: talk about stress and health centered its impact on physical, observable symptoms.

For instance, Rhonda noted that the impact of stress was apparent to her “...because I’ve been pissed off so much my head has been pounding. And I’m sure all that blood flowing to my head is not a good thing.” Here too, we see how a participant used interpretive frames about stress that cast it as a tangible detriment to their physical health. We observed similar narratives throughout our interviews, where participants referred to physical biofeedback mechanisms that indexed their stress levels. For example, Jonathan shared with us that his experiences of distress were most evident through the pain that he had been feeling in his neck. He said that his “neck starts paining bad when someone is mistreating me.”

In these narratives shared by community members, stress is a part of everyday living and the everyday struggles that African Americans experience. Individual narratives provide an attributional logic to the bodily experiences of pain/discomfort. Such narrativizing of stress was not merely an individual phenomenon: it also existed as a social narrative, rooted in the social and economic organization of life in Lake County. The next theme, stress and social structure, addresses the broader context within which African American communities experience stress in their lives.

Stress and Social Structures

Participants’ narratives attributed stress as rooted in the social structures around them. In particular, two sources were identified: employment and discrimination. Localized narratives of stress often centered on discussions of work: to the lack of paid work, the search for work, or attempts to hold on to work. When discussing their sources of stress, participants narrated the ways in which their experience on the job impacted their health. Consider this narrative co-constructed by Sharon:

A big source of stress is my job. I was working at a job you know I’m a health care worker and at the time I had been working as a medical lab technician and I was working crazy shifts, I happened to work a lot of overtime. Several years ago, I was at Methodist Hospital. I had the what do they call it shift, but in any case I worked in one week I worked days which was 7:00 AM to 3:30 PM. I worked evenings which was 3:00 PM to 11:30 PM. I worked the mid-shift which was 11:00 PM to 7:30 PM and I worked midnights all in the same week, and that was very stressful to the point to where that I began to catch ear infections and different things pretty easily and again I wasn’t getting rest. I started getting back spasms you know things like that and I worked that job for about a year and a half maybe, and after I got on a straight shift, I was okay.

Finding enduring employment was a constant source of stress among our participants. Even among those who did manage to find, and stay in a stable job, like Sharon, work-related distress was a defining feature of everyday life. In Sharon’s narrative, the stress from crazy shifts played a role in her susceptibility to frequent ear infections. Meanings of health were constituted amid everyday stressors, especially among those who did not have a job or were just not able to find one. Consider David’s account:

Those that I have talked to, or been around, lost their jobs, can’t find jobs, have problems in the family. Mainly it is a lot of problems that people have to deal with and don’t know how to deal with them, worrying about the situation they’ve come to in their life. That’s why I keep saying, I just refuse to worry about a lot of stuff.

In this narrative, David talked about the seemingly endless sources of stress experienced by people in the community. Note here movement from individual accounts of stress to community level accounts of stress, referring to the various structural level stressors existing in the community. This narrative that David scripts is a culturally common one in Lake County, and is shared by Amanda, who said that “it is easy to feel stressed here. You look all around. Everything is falling apart. [I have] nothing to look forward to.” Evident in Amanda’s narrative is the absence of structural resources at the community level, resulting in what she characterizes as a sense of hopelessness toward the future.

For many of the participants, how they were treated within the larger community was one of the most evident sources of
stress. They discussed the daily negotiation of having to deal with discrimination and prejudice. From running errands to eating out, stress was experienced in the form of mistreatment by community members. Participants connected the stress of structural discrimination and racism to their health status. A great example of this connection is an incident shared by Shaun:

Shaun: You don’t want to get into my big conspiracy theory. There are multiple stressors in the community that goes beyond diet and healthcare choices and all that. That’s what I often say. I tell my wife... I read this study that men go into fight or flight situations... My son has experienced this. So, go to the next town... go shopping, go to the movies, go eat, that’s what they do... So you encounter... so they do this... hate to say it, but they do it only to young black kids, they make them... they don’t allow them into the restaurant unless they have a parent with them... This is especially around the time when there’s a big minority movie coming out, or after a big game, they say that they’re full! Today, today, in this day and age. Last time this happened was Valentine’s day. My wife and I were in [town name], going to a restaurant, he was at a mall with his friends, you know, and called me and said “They are not letting us in the restaurant.” So I drove back, and “yeah right, let my son and his five friends sit down or you are going to deal with something more.” So for him, who knows day to day how those kinds of interactions will affect his health. Just the stress of going into a departmental store where they think you don’t belong.

Author 4
(African American, Lake County resident):
I know what you mean. I’ve experienced it at Wal-Mart.

Shaun: Yeah, you know. You’re being followed day-to-day by security. How does that affect you day-to-day?

Author 4: Yeah, imagine the psychological effect of that...

Shaun: No, no, no not even psychologically, for some people, they react with anger, some with fear, those type of experiences where you just have a higher systolic blood pressure than everybody else, you’re constantly encountering that. And even when you’re not encountering that, you think you might be. So that’s my big conspiracy theory.

This co-constructed narrative depicts the ways in which African Americans negotiate racism in their everyday lives. By expressing his concern about the impact of such institutional discrimination on his son’s long-term health, Shaun charts a direct etiology of heart health (in the form of blood pressure) to such forms of discrimination. While discrimination of the kind experienced by Shaun’s son may not in itself be a novel phenomenon in Lake County, this narrative also attests to how entrenched such discrimination is. Not only do African American teenagers experience it, but they also recognize such behavior as discriminatory and feel the need for them to call their parents, who intervene on their behalf. In Shaun’s narrative, the cumulative impact of multiple discriminations impacts his child’s health in the long run. Shaun’s narrative is a boilerplate for understanding the communication of stress narratives among African Americans in Lake County: structurally embedded stressors have a physical impact on health and members communicate to each other the need to recognize and resist such stressors (like Shaun did to his teenage son). In this backdrop, resistive agency is enacted in micro-practices directed at transforming unhealthy structures of health. We now proceed to share participants’ narratives of agency.

Negotiating Stress, Enacting Agency

Participants often discussed the wide variety of strategies they used to negotiate stressors in their lives. Given that their narratives of health emphasized how stress affected their bodies through various physiological pathways, they discussed their specific solutions for coping with such physiological impact. For instance, Lynne said:

I get to the point where I have to lie down. So I try to have even mind at all times. If someone pisses me off and I know I need to get away I’ll get out and walk around the block a couple times to calm myself down because I refuse to let someone stress me out so bad that I’m busting a vessel in my head.

It is obvious through participants’ narratives that stress is omniscient: what is interesting is how participants find ways to negotiate stressors. Notice that in the above narrative, Lynne does not emphasize “solving” the stressful situation, or working toward eliminating it. Rather, she talks about physically removing herself from the situation, walking around the block, lying down, etc. as different mechanisms toward managing stress. Throughout their narrative accounts, participants actively used a health frame as agentic articulations for escaping/managing stress. We read Lynne’s articulation about not wanting to “burst a vessel” as enactment of an immediate health-related agency.

Enacting agency took the form of “choosing not to worry” (as David mentioned previously) within a context where most participants realize the structural context and the economic bases of stress. Participants talked about “keeping a
perspective,” so that they could keep work from getting to them. Troy elaborated on the economic sources of stress, and then outlined the strategies of resistance he adopted:

Author 3: What kind of things contribute to stress?
Troy: Work. Worry about stuff. That’s mostly work. Don’t let others … sometimes people can stress you out... Bills can stress you out. Lot of things contribute to stress and I refuse to let them stress me out. Like I used to get stressed about bills and creditors and now ... I look at it this way, when I die, they’re still going to be there or they are still going to expunge it. So they call my house, they talk their little stuff, and I just tell them, I have no money, do not call me. Or either I’ll tell them I’m dead.

Author 3: You tell them you are dead?
Troy: Yes.

Author 3: How can you tell them you are dead?
Troy: They don’t know it’s me.

Author 3: Oh they don’t know it is you.
Troy: They’ll call and ask for me. I’ll say, what is this pertaining to? They say, it’s a personal matter. I say, I’m sorry to inform you he passed away a month ago.

Author 3: Oh really!
Troy: And they go quiet, and they go, “Oh really!” And then they say, “What happened?” Says, “Well, he was in a car accident and got decapitated...” And then they go, “Oh my God!” I go, “Ya! It was a shock to us too.” She goes, “Well, who is his family?” I go, “I have no idea of his bills, his family and stuff, I’m just a friend of his. He has no assets. I don’t know what’s going on. I just know that he’s gone. Could you do a favor?” They go, “Uh anything.” “Well, could take his name off your list?” “Sure.” And then they don’t call anymore.

Author 3: Wow!
Troy: And they used to stress me out. They’d say, “We got to do this and blah, blah, blah. And then you just like to … you know what life is too short, I’m too old for this...well, how do you used to make to a living? One woman called and she asked me, well, how do you sustain yourself? I told her I was a male prostitute and she hung up.

Author 3: She hung up [she laughs]? You’re having fun on the phone.
Troy: So I don’t let them stress me out.

Besides the irony of Troy faking his own death to avoid debt collectors, this narrative is fascinating in how it connects the very real and cumulative effects of debt-related stress to the use of farcical communication strategies. As scholars interested in agency, we see this narrative, laced with self-deprecating humor and sarcasm, as a prompt to question the conditions wherein individuals like Troy would rather people think him dead, rather than face the continual impact of being poor and unemployed at an advanced age. Articulations of agency are deeply intertwined with the ways in which structurally situated stress is experienced.

Here is another co-construction in our conversation with David wherein he shared with us his strategy of “living in the present” in order to cope with stressors:

David: Right, like I said right now, I know I have to eat to live… so when it comes to just say my car, I don’t want them to take the car. So, I might have to be late on the payment, which is going to make me worry because that’s going to make them call me and stress me out, but I also know I got to eat. So I’m going to do the first thing what I think is the best for me: to eat first eat and worry later and also pray that something will come up that I can get this car note paid and it usually does by hook or crook. So I just like to play it by ear. I do what I have to do for the moment or for the time is now or if they take that car from me I still got to eat. I’m going to do what I need to do and eat. As far as getting around, there are other options… Like call somebody or whatever. I think I have done enough favors in my life. They don’t owe me nothing, but I would like to think in turn that I do, went out of my way a lot, maybe somebody might do it for me. So right now, when it comes [down to] eating, this car can be taken away. I wasn’t born with the car, but I know I have to eat to live and I’m going to do that. So if they take back their car, I can’t eat that car. I’m going to have me some food to eat you know. I’m going to do what I need to do.

Here, David shared the ways in which he prioritized among the several economic challenges that presented themselves every month. Health is managed—and understood—as a constant set of choices and sacrifices among essential goods and services. If one such essential could be paid for, a car payment, for instance, then it had to come down to luck, chance, or the relationships among community members. Here, agency is the ability to make choices, even if those choices are circumscribed within an extremely narrow parameter: that the car will get paid for, through luck, or through prayer. “Living in the present” is a coping strategy through which participants evaluate what is truly essential even within such resource-limited contexts. Such acts of (re)evaluation need to be theorized as agentic expression: a recasting of the lack of self-determination and control that forms the core mechanism of how chronic stress impacts bodily health and well-being. “If they take back their car, I can’t eat that car…” is a way to disassociate from the stress constituted amid the struggles with structural resources.

Discussion
In this article, we explored how health narratives voiced by African Americans living in Lake County construct the everyday enactment of health disparities. Participants’ co-constructed narratives presented health in the realm of stress, offering a locally derived conceptual framework for understanding the everyday experiences of health. The interpretive frameworks played out within these narratives are closely intertwined with the everyday experiences of being African American in Lake County, in terms of the day-to-day struggles to make a living...
as well as in the impact of institutional racism on health. The everyday enactment of health disparities on African American bodies in Lake County is the pervasive and chronic presence of stressors, stressors that are felt through financial and economic challenges at the individual level, communicated through shared experiences at the social level, and are negotiated through individual and social agency.

In this sense, the primary contribution of this article is the demonstration of participants’ co-construction of narratives of stress as being central to the impossibility of health, and as being linked to specific physiological reactions like heart disease and blood pressure. Participants’ “lay narratives” of stress highlight the need for, and at times corroborate the complex relationship between stress and health offered in a substantive body of literature (Thoits, 2010; Williams, Yan, Jackson, & Anderson, 1997). From a CCA perspective, the narratives voiced by the participants reassert the importance of attending to localized disease etiologies and health experiences of marginalized communities as entry points for situating health amid structural inequalities. Our co-constructions are testimony to the urgent and continual need for health communication theorists and practitioners to practice the simple—and yet fundamentally complex—act of listening to marginalized voices as an “entry point” to theory building.

In the course of this culture-centered project, concepts like stress, discrimination, and health disparities emerged through conversations between community members and the academic–community team. Through a process of co-construction, these concepts were challenged, opened up to questions, and further developed as we participated in further conversations. For instance, even as our interviews started articulating consistent entry points for understanding African American health in Lake County in terms of stress, a community-based physician on our advisory board started interrogating the linkage, suggesting that there is perhaps not enough evidence for this link. This point of interrogation opened up the space for debate and dialogue in our advisory board meetings, resulting in the conclusion that our academic–community partnership needed to push for greater studies to be conducted to empirically document the link between sources of stress, levels of stress, and stress-related health outcomes, also thus pushing the realm of discourse in interpreting health.

A second contribution of this study is application of a narrative paradigm to study the cultural, structural, and agentic aspects of health disparities. By emphasizing the “everyday enactment of health disparities,” our study demonstrates the utility of taking a narrative approach to understanding physical illness experiences. Connecting existing work in narrative theory (Garro & Mattingly, 2000) to the framework of the CCA (Dutta, 2008), narratives of health offer a framework for understanding the meanings of stress at the intersections of culture, structure, and agency.

In our participants’ narratives, health is marked by its absence, through the physical manifestations of stress on the body. It is felt in the form of anger, frustration, and dejection, physiologically felt in the numbness of limbs, headache, neck pain, etc. In sharing the role of stress in defining their understandings of health, community members note the immediacy of the bodily experiences. The body becomes the tool for gathering knowledge, the site that provides the building blocks for participants’ narratives. Our work develops Garro and Mattingly’s (2000) notion of health narratives as both “construct and construction,” in emphasizing narrative as a mode of organizing experience rather than as a form of accurate representation of physical experiences. In other words, we argue that a communication-driven focus on the study of health disparities ought to be less concerned about the ontological basis of health narratives (like the relationship between stress and “bursting a vessel in one’s head”) or about developing culturally sensitive message strategies (Dutta, 2007), but instead about working with narratives as “sense-making” and “decision-warranting” tools. Narratives work as schemas that allow for individual experiences to be situated within the broader context of social organization such as institutionalized discrimination, lack of employment, lack of education opportunities, etc. Narratives like David’s refrain from “choosing not to worry,” or “I can’t eat the car” are individual instantiations, but when situated within the context of the material deprivation of Lake County demonstrate the importance—and relevance—of communication scholarship.

Our participants narrated their experiences of health by referring to the physical symptoms of stress that become most apparent to them when dealing with problems that were fundamentally social in nature. Health was connected with the contextual features of social structures that community members negotiated in the form of experiences on the job, searching for a job, experiences of racism, etc. Therefore, when referring to health at an individual level, participants also articulated a broader context of community health, referring to the importance of stress in “African American health.” The story of Rhonda joins with the story of James and other community members, in putting forth a broader context within which localized articulations of health come to be understood. Stress emerged as a community-wide narrative, interconnected through the stories shared by participants. Bodily experiences of health were connected to interpersonal experiences, and were further interrelated to experiences in negotiating the structural context of African American health.

A final contribution of this article is the potential utility of the CCA for studying current trends in the US health disparities from a communication perspective. While the CCA was developed as a critique of the simplification and objectification of non-Western cultural models of health, and sought to situate non-Western “cultural” behavior within structural and agentic factors (Dutta, 2004), this article represents the utility of this theoretical lens in studying communicative aspects of health disparities within a rapidly diversifying demographic in the USA and in other Western countries. The CCA offers a space for interrogating health structures within the global North through journeys of solidarity with subaltern communities residing in its peripheries and interstices.

References


