Navigating Publishing Critical Health Communication Research

Nicole Hudak*

Departments of Communication & Philosophy and Public Health, Keene State College, Keene, NH, United States

Publishing critical health communication scholarship comes with challenges. In reflecting on my own experiences, I discuss the ways in which health communication is designed to favor post-positivistic research. Through looking at reviewer comments and general academic conversations, I discuss the barriers critical health communication scholars face. In the end, I provide suggestions for ways that critical health communication scholars can move forward as leaders in our subfield.

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A rejection. I swallowed my disappointment and waded through the comments. Scrolling through I see "LGBTQ people are no longer marginalized" listed as a reason for not accepting the article. The comment burned. As a scholar I was frustrated. As a queer person, I was livid. Working with my own marginalized population as a queer person, I found a deep connection in my research. However, I was not prepared for the multi-layered rejection. It was not only my scholarship that was being rejected but also my identity as a queer person.

In my experience and through conversations with other related scholars, it appears that critical health communication scholars undergo intense scrutiny in their work. When seeking out outlets in both conferences and publications we can struggle to find a home. As a queer critical health researcher, I find myself battling between representing my identity and pursuing health communication scholarship. Facing rejection, not for a lack of quality in my work, but because of what my work represents, I have had to find ways to navigate within the system that promotes post-positivistic perspectives. In this essay, I explore my experiences of attempting to establish myself as a critical health researcher through both publications and through finding a place within the academy.

DEFINING CRITICAL HEALTH RESEARCH

Before delving into my experiences, I find it pertinent to establish how I approach and understand critical health research. Dutta (2010) explained that critical health perspectives focus on the ways in which knowledge is produced. Knowledge is produced in a way that legitimizes power structures that continue to perpetuate inequalities within both health and healthcare. Knowing that knowledge influences power, critical health communication scholars then, "interrogate the values intertwined in the knowledge claims made by biomedicine" (Dutta, 2010, p. 535). With the understanding that knowledge reinforces power, what we designate as "truth" is then also a product of power relations (Lupton, 2012). Critical health communication research recognizes that truth and knowledge are both constructed and reinforced by power relations and we should, therefore, be skeptical of those claims.

When looking at power relations, critical health communication scholars take it upon themselves to challenge these systems. Traditional forms of health communication are "embedded in our taken-for-granted assumptions about what it means to be healthy, what it means to be ill, and how we approach disease and illnesses" (Dutta, 2008, p. 2). Critical health communication pushes

back on these assumptions through the deconstruction of dominant frameworks, particularly of health risk (Dutta, 2010). Health risk is often associated with problems of individual choices (Zoller, 2005). In framing health risk through personal choices, there is a lack of emphasis on how structural barriers may be influencing these decisions. When using a structure-centered model, "communication can be conceptualized as a process of constructing, negotiating, and transforming cultural meanings through interactions with and transformations of structural limits that constrain the lives of marginalized people" (Dutta-Bergman, 2004, p. 1119). By exploring health through structure and power, there is the potential to get at the underlying issues of health risk and healthcare that cannot be interrogated through traditional, post-positivist approaches to health.

In this essay, I refer often to post-positivist perspectives due to post-positivism being the dominant perspective utilized by health communication scholars. Post-positivism is not inherently bad. That is not the point of the essay. Rather, the approach can conflict with a critical perspective. Underpinnings of truth are debated between these two approaches, causing critiques on both sides. Therefore, when discussing post-positivists, they are not the "bad guys" but instead are positioned as the dominant voices in the discipline of health communication.

As a critical scholar, I also believe in the self being connected to my identity as a researcher. My own marginalized and privileged identities are intertwined in my scholarship. I cannot part one from the other. Often, my research is driven by my experiences as a queer individual. The questions that began my scholarship were directly related to my stories. When I was out as a queer person, I began to question how or if I should share my sexual identity with my provider. In these questions, I started to pursue my research. In recognizing this, I am placed in an insider-outsider status (Sherif, 2001) with both scholarship and participants. I am part of the academy and benefit from it, but I am also a queer person who is ostracized by those in power (see Allen, 2011). Being a critical health communication scholar, I am balancing these identities in the negotiation of presenting and publishing my work. Beyond my individual experience, it is not uncommon for critical researchers to study populations they are a part of. I am not only considering my identity as a process of self-reflection, but also how my identity connects to how I am (un)able to navigate the health communication field. We cannot divide ourselves from our identity or our research. Ellingson (2006) noted that often social scientific health research has separated the body from the research, which is problematic because our bodies are sites of knowledge. She contends that where our bodies are positioned, what groups our bodies belong to, and how we use our bodies matters in research (Ellingson, 2006). I contend that we embody our identities into our research and therefore, my queer identity is a crucial part of my work as a critical health communication scholar. Finally, recent conversations surrounding the communication discipline demonstrate how identity and scholarship go hand in hand (see the special issue on Merit, Whiteness, and Privilege in Departures in Critical Qualitative Research). Who we are and who we choose to research are deeply embedded in our institutions. In the next sessions I will explore that how we are evaluated by our peers and

superiors can be based consciously or subconsciously on not only the type of research we engage in, but our positionality. In turn, those results are indicated by what gets published and what gets recognized in our field.

THE PROBLEM WITH PUBLISHING

I cannot help but note the irony of discussing the difficulty of publishing in a published article. While this article was embraced by the editors, my other work has not always received such a warm welcome. In considering the underlying reasons behind the struggle, the prominent barriers are reviewers and journals promoting post-positivistic work.

First, health-based journals and conferences tend only to accept social scientific framing of research. When presenting on a queer health panel at the National Communication Association conference (NCA) a few years back, I pointed out that every paper submission on the panel did not send their health research to the health communication division. Knowing our work would not have been accepted to the health communication division, we all ended up submitting individual papers to the Gay, Lesbian, Bisexual, Transgender, and Queer (GLBTQ) division instead. This trend has continued as I had recently served as a respondent on a queer health communication panel that was advised to send to the GLBTQ division, rather than the health communication division. We are constantly warned about the inability of health communication to engage in interpretive/critical scholarship. It is not that the division purposefully provides a check list of whether the paper is quantitative or qualitative, post-positive or critical, but the reviewers who rate the work seem to be struggling on how to evaluate research that does not fit within the paradigm that they align with. Therefore, little scholarship seems to be accepted in the health communication division that is not classified as social scientific. And as a young scholar, I do not want to waste my time sending quality articles to a division that will most likely reject my work. As scholars, we have constant conversations about which health communication journals will begin to even look at critical health work, much less provide a fair and quality review of the work. I have been grateful that my work has been accepted to health journal outlets, but it was not without its own difficulties.

Second, the reviewers for conferences and journals are often post-positivists themselves. When being asked to review, we are often asked what our specialty area is and perhaps theoretical expertise. Never have I been asked about my approach to research. Sometimes they may ask about methods, but methods can cross over to varying perspectives. Because most health communication researchers are post-positivists, they are the ones reviewing the work. Dutta-Bergman (2004) pointed out this issue by stating, "scholarship and applications in the realm of health communication continue to echo voices of those with power and access" (p. 1107). Those with power and access includes the voices and perspectives of those who run divisions at conferences, editors, and reviewers. Having post-positivist voices are not inherently a problem, the issue is that health communication is traditionally framed

under that perspective. Health communication was built on a post-positivistic framework. As experts in the field, health communication scholars are expected to know the foundations, requiring post-positivism as the lens. Those who take on interpretive and critical approaches to health communication must first learn the foundation and then learn their own paradigm as secondary components. And while interpretive and critical scholars are trained to read and analyze social scientific research, the inverse is not true. Post-positivists then review critical research without knowing the basic principles of that world view.

An example of how critical scholarship in health communication is misunderstood can be seen with my own dissertation defense. My dissertation was a critical approach to studying queer pregnancy. When my committee member, an interpretive health communication scholar, asked whether I felt my interpretations were biased, I responded with "absolutely." She was shocked with my blunt answer, but as a critical scholar, I recognize that any analysis I engage in is shaped by my own perspective. Further, my advisor and I often got into disagreements surrounding my analysis. In using a critical analysis, I looked at the underlying dominant discourses that were being used by my participants as Lawless and Yea-wen (2019) explained that is a way to pursue critical analysis of qualitative interviews. Because my advisor was not a critical health communication scholar, he felt that I should only analyze what was directly spoken by the participants, instead of exploring the power structures that potentially underlay the discourse. Both my committee member and advisor were not trained in critical perspectives and therefore had some difficulty understanding my approach. It was not that they were inherently bad for having diverse approaches, but they struggled to fully engage in my scholarship and preferred paradigm.

Understanding the predicament critical health scholars are in when trying to publish research leads me to my own experiences. While my reflections are based on my sole experiences, they can still reflect upon those larger issues. In these next sections, I will discuss the juxtaposition of behavior and identity and the disclaiming of expertise.

BEHAVIOR VS. IDENTITY

Identity can become a place of contest in health research. There is a need to strip the identity from the person and focus on the behavior. After all, behavior is changeable; identity is not. I cannot simply change my identity to improve health outcomes. As a researcher, when I started my work on queer health, I made the firm decision to focus on identity. Other researchers have countered this explanation by pointing out how identity matters when bringing up partner relationships that can be discussed in a health setting (Bjorkman and Malterud, 2007). As a person who has experienced discrimination within healthcare, my discrimination was not only based on sexual health practices, but also the mere mentioning of a same-sex partner. Even in providing an explanation of why identity was forwarded in the research, reviewers have not been satisfied. I have experienced

pushback by reviewers saying that identity is complicated and therefore too difficult to consider in a health context. When submitting a manuscript to a health journal, a reviewer claimed that it was best to focus on behavior by using terms, such as men who have sex with men. While this use of a population can be helpful in some research, it can ignore the impact of identity outside of sexual behaviors within health(care) interactions. Focusing solely on behavior does not allow for the consideration of power structures that promote dominant identities.

The frustration with encountering reviewers who do not understand why behavioral practices are problematic grows when they do not seek to even recognize why they are important. In Hudak and Carmack (2018) article, we explain that a queer individual may seek healthcare by asking for sleeping pills to manage a breakup with their partner, wherein which they might disclose a sexual identity, no sex is actively mentioned. However, one reviewer wrote, "Well that's true of a patient of any sexuality—heterosexuals struggle with breakups too." What the reviewer refused to consider was that a healthcare provider would not bat an eye if a heterosexual individual mentioned a cross-sex partner and therefore did not need to worry about that encounter. The unwillingness to engage in the marginalized experience of a queer individual in a healthcare setting then reinforces the idea that the work is not needed, or that behavior should still be the forefront of the research, erasing the need for critical perspectives.

One of the larger issues I have encountered when trying to publish is to have reviewers recognize the problem I was articulating. Scholars are willing to line up and back the idea that queer health matters in the context of HIV/STIs (Dillon and Basu, 2014; Khosropour et al., 2014; Schwartz and Grimm, 2019). Yet, often the discussion is solely around behavior by focusing on sexual risk. The disparity framework functions here because this is a stigmatized, negative health condition that is seen to be based on individual behavior, rarely recognized through structural barriers. HIV/STIs also reinforce the deviant narrative of queer folk. HIV/STI research is important, and we can consider behavior in health research, but we cannot forgo identity in favor of only behavioral, sexual acts. In promoting a behavior only focus, health communication research can then miss out on key healthcare experiences that promote heteronormativity that a critical perspective would explore.

Behavioral approaches to health do not account for structural barriers or marginalized identities. Health communication largely approaches health from individual behaviors (Zoller, 2005). Moreover, focusing on just behavior does not provide room or understanding for critical perspectives. The history of health communication research has shown little inclusion of critical perspectives as between 2000 and 2010, only 1.4% of research held a critical paradigm (Kim et al., 2010). Further, when looking at Kim and colleagues' (2010) assessment, their definition of critical health research stated that "A critical paradigm encompassed studies addressing power, structure, and/or social class issues surrounding the knowledge, attitude, and behavior of underprivileged groups with regards to health problems or risks" (p. 491). The focus was still being presented on risk and behavior, over glossing the discussions of structures and

dominant groups. Our goal then as critical researchers must be to convince the health audience that identities matter due to power imbalances that can then create structural barriers and health discrepancies.

DISCLAIMING EXPERTISE

Explaining my own experiences to me. A simple sentence, written in a talk down manner. Instead of "LGB patients," please use "patients who identify as lesbian, gay, or bisexual; please use person-first language, as that is most up to date terminology." Was this reviewer inherently wrong? Possibly not. Yet it still stung. As a queer person, I never say my identity as an afterthought.

A challenge of writing and attempting to publish critical health communication work is that there are only a few individuals who are critical health scholars and review for the journals. When being assigned reviewers, the reviewers are less likely to be experts in the field that know the content area, understand the methodological approach, and can analyze critical scholarship. Having knowledge in one of those areas can cause deficiencies in others. In my own publishing experience, I have had reviewers who try to tell me that how I am writing about my topic is wrong. While this is common amongst any publishing experience, I have often found that the reviewers do not assume I have any expertise on the topic and my identity as a member of that community is left behind. In the above experience, the reviewer was attempting to tell me, the author, that how I wrote about queer identity was incorrect and perhaps harmful. The reviewer claimed that the literature states person-first language is the correct approach, even though that is not the case. The power dynamics that are occurring here are that as a queer person, I am being told how to identify myself. The reviewer is stating that all queer individuals (including myself) should use first person language. As an author, I am told that I am mislabeling a community. The reviewer is asserting their power and authority to make a claim and I, as the one without power as the submitting author, must obey.

When working with reviewers there is the expectation that authors must concede several of our stances to be published. The reviewers have the upper hand. In moments of misrepresenting marginalized populations, I must take pause. Do I disregard the participants to further my own academic cause? Should I go along with statements so that at least the work sees the light of publication? Or do I stand up and potentially get rejected? In considering the person first language, I felt a need to stand my ground as both a critical health scholar and a queer individual. The need for a co-author was great here. I had to figure out how to word my response that was not just anger forward. After a discussion with my co-author, I wrote my response to the editor. In listing several reasons why I did not comply with the reviewer, I stated, "LGB individuals often label themselves as a 'gay person.'" Having this claim reiterated that many queer individuals do not say I am a person who happens to be queer when stating their identity. I also added that "the first author identifies as a 'queer woman' and follows that particular convention." Here I attempted to establish my authority as part

of this community, something that would not be granted to non-queer folk. Having looked back at the other published literature I then added: "most of the current published research does not use person-first language when speaking about the LGBTQ population." Here I continue to establish authority, but as an expert on the topic at hand. Finally, with the recommendation from my co-author, a non-critical scholar, we added "making the changes for how the population is addressed with increase the word count significantly." I resented this use of argumentation. The word count does not consider the power dynamics of representation of queer folks in health literature. Yet, my co-author argued that if the editor and reviewer do not care about the first claims, this would be the solid back up argument.

Fortunately, we were able to keep the identity first language. But the experience articulated a problem that critical scholars may experience when publishing. Reviewers typically do not consider the power in naming marginalized groups, especially in a field of health communication that aligns with post-positivist perspectives. They may not have expertise on the topic but can still assume authority. As a critical scholar, I had to contemplate whether the argument was worth the rejection risk, my own power dynamics of having the option to mis-identify groups, and/or how to present a compelling argument. Having a non-critical co-author provided me with a balance that can be useful for other scholars. We can still have a critical voice and communicate with a post-positivist audience.

WHERE DO WE GO FROM HERE?

This essay has articulated the struggles I have faced with publishing critical health communication scholarship. While much of the essay was based on my experiences, I believe that many others have similar stories based on informal conversations with fellow colleagues. Our collective stories then beg the question, where do we go from here? My answer is simple. Keep writing. Send out the scholarship. We cannot create change if we do not try. However, it is more than just publishing. We need to become voices in the discipline. There is a need for critical scholars to become editors, division leaders, and reviewers. By taking leadership roles, we can uplift critical voices in health communication. Critical health communication scholarship can become part of the norm, but only if we are active voices coming from within. The burden should also not be carried alone. If struggling with an article, it may help to bring on an additional scholar. One of the ways that I have succeeded in publishing my work was by bringing on other experts and authorities in the field so that if something too outlandish was said, I had the ability to fight back.

How we run our divisions can also change. First, I think there needs to be space for critical and interpretive research. The health communication division at NCA should specifically set aside several panel slots for critical and interpretive health communication scholarship and announce these intentional slots in the call for papers. By communicating that there is space for this type of scholarship, more critical health researchers will

be likely to submit their work. But it cannot just be providing space, there needs to be critical scholars evaluating this work. It will not help to continue the model of post-positive researchers evaluating critical scholarship. Health Communication needs to specifically seek out critical and interpretive health researchers to review this work. Finally, there can also be specific awards and scholarship for critical health scholarship. Another reason for not submitting to the division is that critical scholarship is not rated on the same plane as social scientific scholarship. By having an award, critical health scholars may believe that their work will have a chance to be recognized and that their work is valued.

Finally, we can also create mentorship programs for younger scholars attempting to find their voice. I have been very fortunate to receive informal mentorship from several scholars, including critical health communication academics. They have been foundational in my pursuit of publishing my research. The creation of mentorship programs at regional and national levels can help guide future and current critical health communications scholars with helpful tips and feedback on how to publish their work.

Even with the struggles I have faced, I still believe in publishing critical health communication scholarship. Critical health scholars provide a needed voice in the field that questions power dynamics and structural barriers that construct health needs. Without exploring power dynamics and structural barriers, we can miss key conversations surrounding access, social inequities, discrimination, and so on. As I move forward in my career, I hope that the road to publishing critical work in health communication becomes less challenging and more accepting of diverse perspectives.

AUTHOR CONTRIBUTIONS

The author confirms being the sole contributor of this work and has approved it for publication.

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