“DOING” CRITICAL HEALTH COMMUNICATION. A FORUM ON METHODS

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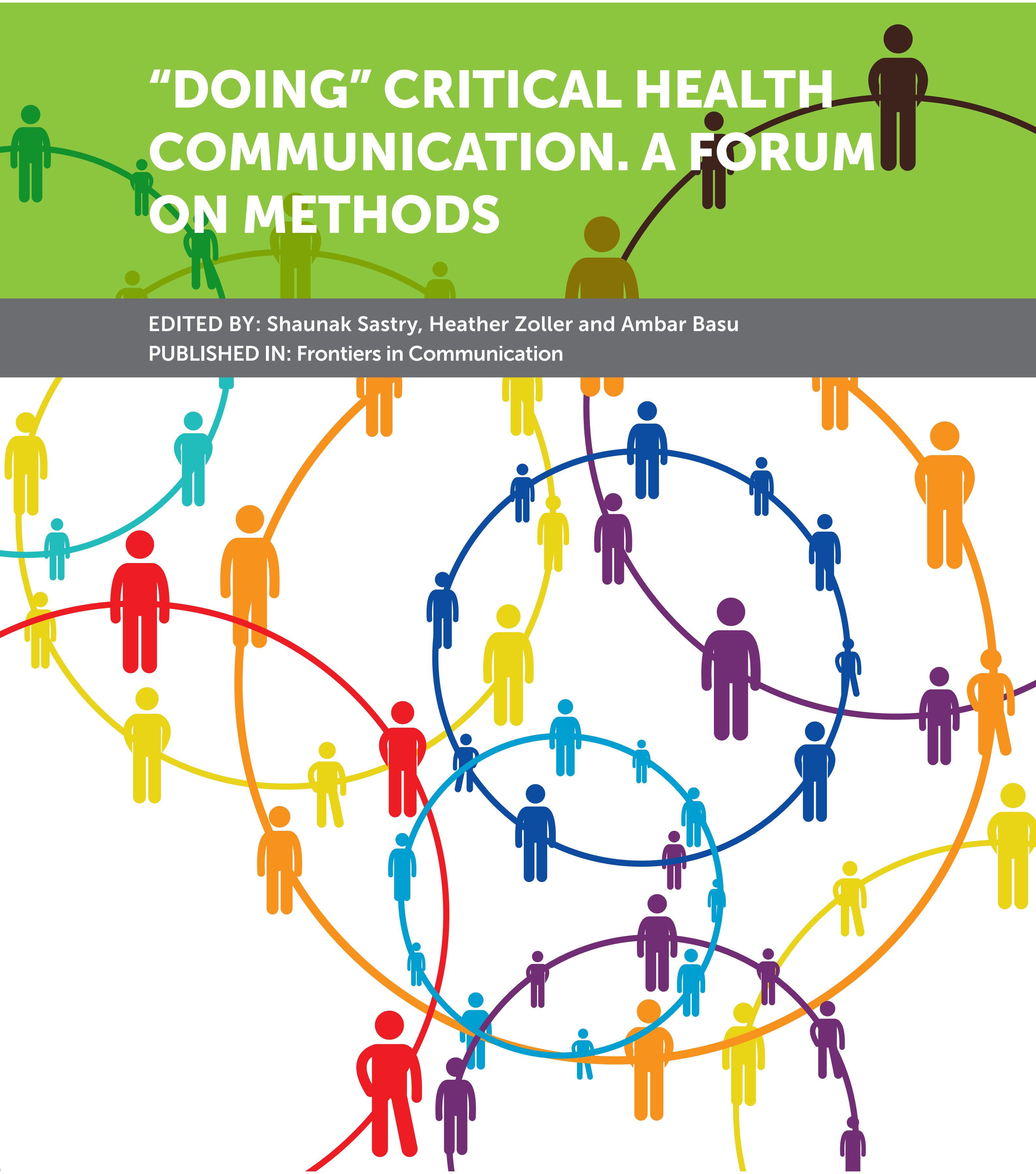

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“DOING” CRITICAL HEALTH COMMUNICATION. A FORUM ON METHODS

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EDITORIAL
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Editorial: Doing Critical Health Communication: A Forum on Methods

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Editorial on the Research Topic

"Doing" Critical Health Communication. A Forum on Methods

The assumed premise of health communication research is straightforward: improving communication processes across all health-related domains. Communication between providers and patients, public health messaging, health literacy training, culturally competent healthcare, health status sharing in families, workplaces, and small groups can all fit within the broad definition of health communication. However, philosophical differences in what communication means–or for that matter, what health means–result in a complex, multi-paradigmatic field of study. For instance, viewing communication primarily as information transfer leads to a different trajectory of research and scholarship than a view of communication as the constitutive process of meaning making. Similarly, conceptualizing health as a means of achieving social concordance or even control vs. as a site of social struggle leads us different places.

Within the well-established field of health communication, a preponderance of published research continues to be rooted in communication models that derive from social psychology and information science. Consequently, emerging issues, new theoretical and methodological directions, and ethical challenges define the landscape of the field. For instance, we have witnessed a significant rise in interpretive research focusing on the social construction of meaning. However, we believe there is more work to do in nurturing critical health communication [CHC] perspectives.

The primary rationale for this research topic was to describe multiple ways to engage in CHC methodologies through a set of short, "how-to" articles. The original impetus were two roundtable panels (convened at successive National Communication Association conventions) to gauge the trajectory of CHC in the decade after Zoller and Kline's review of the contributions of interpretive/critical health communication research in the Annals of Communication (then called Communication Yearbook). One of the things we recognized in those panel discussions was that CHC was still considered a niche sub-discipline or area within health communication, and consequently, students and young scholars who were interested in CHC often did not receive formal guidance in this area, notwithstanding the dramatic increases in CHC-fueled work being published in our disciplinary journals, and/or presented at conferences. Even for scholars familiar with the intellectual terrains of poststructuralism, postcolonialism, the "linguistic turn," hermeneutics, phenomenology and critical theory, there was a gap in documenting these theoretical concepts into concrete ways of "doing" health communication research.

In calling for papers, we urged potential authors to ask, "What makes your work critical?" How do methodological practices illuminate the role of critique? What are the ontological and epistemological implications of doing CHC? How is CHC related to critical praxis? How does "doing" critical work engage with/deviate from the broader interpretive move toward discourses/

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texts? What do recent provocations around the “return to the material” in Communication scholarship mean for CHC researchers? How is CHC situated to respond to widening racial, gendered and other social disparities in health across the globe? Finally, how do CHC researchers situate their own privilege and conceptualize embodied risk through their work? The fourteen articles that comprise this collection, selected from the 30 + abstracts submitted for consideration, and shortlisted from 19 full-text article submissions) respond to this prompt in unique, individual ways.

Of the fourteen articles, five report on new/original research, four offer ‘Conceptual Analysis’ or brief essays on a particular concept. Another four are short “Perspectives” on varying issues concerning CHC, and one is a Brief Research Report. As to our remit of a “how to” for CHC, the articles offer pedagogical insights on CHC methods in a variety of ways.

Zoller and Kline’s 2008 drew attention to both shared attributes and key points of difference in interpretive and critical health communication. One of our goals for this topic was to theorize their differences as well as their “blurry edges.” Anne Kerber’s essay addresses longstanding conflicts between a critical “hermeneutic” of suspicion that interrogates relations of power and an affirmative stance that seeks positive models of critical social change.

A second rationale for this collection was to re-establish the disciplinary history of the efforts of CHC scholars. At the abovementioned conference panel discussions and through our own anecdotal experience, we have learnt that the multi-decade project to critique, de-parochialize, globalize and queer the body of the discipline (and consequently, its journals and editorial boards), led by women, scholars of color, LGBTQ scholars, and scholars from the Global South, has not been documented or set into the received intellectual history of the field (in contrast to cognate areas, like critical organizational or critical management studies). This absence influences the diffusion of our work. It also makes it possible for other scholarly collectives, notably our colleagues who coalesce under the “Rhetoric of Health and Medicine” or RHM, whose work we admire, review and support, to largely ignore this history and the contributions of CHC scholars in opening up space for critical/humanist inquiry in this area. In that sense, we seek to make explicit the politics, the pragmatics and the real-life implications of doing CHC work. As a foundational scholar in the area, Heather Zoller’s essay derives from her extensive work in the field, and outlines how the politics of academic training, visibility, and publishing intersect in pursuing a trajectory of critical health communication research. This essay is an excellent entry point for this research topic.

Essays in this collection model different forms of critical analysis. For instance, Carter and Alexander’s original research is an exemplar for connecting race, class, historical positioning, and health communication practices. Their interview-based original research highlights the voices of African American farmers, revealing how their issues and interests have been silenced in discussions about United States farming. They connect these erasures with broader political discourses about diet and health disparities.

Khan et al. model critical ethnographic analysis through their study of *Ashodaya Samithi*, a sex worker collective in Mysore, India. They offer narratives that highlight resistance and alliance building that are imperative in order to invert dominant discriminatory notions of nationhood and citizenship that have and continue to violate health and rights of marginalized communities. Much of the critical work in health communication has emerged from the global South, espousing a critique of the West-dominated nature of communication theorizing and global health policies.

Dutta and his team provide a primer in a Marxist approach to critical theorizing, with attention to the global subaltern. The authors draw from their embodied culture-centered research engaging in activist interventions that aim to disrupt Whiteness and associated capitalist and colonial logics. The authors challenge us to consider what counts as resistance organizing in ways that provide an interesting counterpoint to Kerber’s essay. Such tensions in what counts as “critical” research in health communication continues to be an important fault line in our field. Metatheoretical differences in conceptualizing the role of the critic in health communication manifest in methodological and pragmatic differences in what research looks like. One such difference is in the practice of what some scholas call ‘critical reflexivity’

Critical reflexivity–or the continual introspection of how analysis reveals the motivations of the analyst as much as it says something about that which is analyzed–is a governing principle guiding the ethical conduct of critical research. Rebecca de Souza’s essay interrogates how the literature on critical reflexivity–what she calls the “self-other” hyphen—predicates a white researcher introspecting on their ethical analytical practices as they work in communities of color. However, flipping the trope, de Souza’s essay offers a fascinating look at what happens when a person of color navigates analysis of predominantly white spaces. Through an analysis of the responses and challenges to her work by peer reviewers, commentators and colleagues, de Souza offers a window into the “micro-politics” of knowledge production. Her work offers practical suggestions for scholars of color to challenge the hegemonic assumptions that emerge from working in white spaces.

Similarly, Leandra Hernandez and Sarah De Los Santos Upton provide an exemplar of the power of critical reflexivity and the need for critical praxis through social justice activism. The essay blends discussion of their research and activist work, describing the intersectional approach they have taken to health communication research at the United States-Mexico border. Situated as Chicana feminists, they have investigated gendered, racial and class constructions in the context of reproductive justice, violence, and immigration. The authors describe how their work has necessitated a blending of theoretical and methodological approaches.

Critical reflexivity is also an important tool in Smita Misra’s essay, which centers around the concept of migrant trauma. As encapsulated by their experiences in a participatory theater project that purportedly allowed for refugees to cope with trauma, Misra offers a critical reflexive account of how well-meaning, “participatory”/critical projects can offer limited/constraining understanding of the lives of the vulnerable populations they serve.

Nicole Hudak’s essay discusses challenges in publishing research that does not fit within post-positivism, calling for more advocacy of qualitative and critical research. In addition, the essay challenges all of us to interrogate reviewer practices that reinforce heteronormativity and create barriers to research addressing LGBTQ + health care experiences. This turn to embodied identity is further crystallized in Ellingson’s work, which theorizes embodiment more centrally.

Embodiment becomes sensorial in Laura Ellingson’s essay. Sensual intersubjectivities that blend the senses, the motors, and the material, Ellingson explains, are crucial to critical health communication research methods because interrupting discourses on/of what makes certain bodies/citizens ‘healthy’ and ‘normal’ calls for a sustained practice of sensorial reflexivity.

If critical reflexivity is one way to redefine the “blurry edges” between interpretive and critical approaches, then Sastry and Basu’s essay offers a methodological warrant to use critical reflexivity as a practicable method for analysis in health communication. The essay elucidates an approach blending culture-centered analysis, abductive analysis, and critical reflexivity in a post-COVID world. Departing from their ethnographic work in the culture-centered tradition, the authors offer a framework to analyze health discourses using the early responses to COVID-19 as an exemplar.

Several essays offer methodological innovations in the doing of critical health research. Sarah MacLean and Simon Hatcher write about the walkthrough method in their essay. The walkthrough method offers a viable process to scrutinize the architecture of a health technology tools –- the BEACON Rx Platform in their case –in terms of expected use and consequent implications of access and equity. This method also creates spaces for questioning the discourses inherent in health technologies that frame dominant understandings of how to be in “good” health.

Wendy Pringle provides a new methodological tool for critical health communication scholars, particularly those interested in textual/rhetorical analysis and policy discourses. She adapts the “What’s the Problem Represented to be?” (WPR) approach from the field of discursive policy analysis. The paper uses the illustrative example of the legalization of medical assistance in dying in Canada. The WPR method facilitates attention to evolving discourses of problem constructions, and she describes the implications for people with disabilities, including what is said and what is left unspoken. The method addresses social change, including policy critique, and advocacy as a form of resistance.

In our call for papers, we hoped to collectively articulate (and complicate) what exactly we mean by “critical” in CHC. In addition to the models we have discussed, Kim Kline and Shamshad Khan call attention to the need for CHC scholars to speak to both internal and external stakeholders. Their essay signposts the possibilities and challenges for CHC scholars to engage in “transdisciplinary” collaborations within and without the discipline of health communication.

Speaking of collaborations, this research topic would not have been realized without the collaborative efforts between the contributing authors, the editorial team, and most importantly, the large number of reviewers who volunteered their time and intellectual commitment to this cause–not to mention adapting their reviewing practices for Frontiers. While open-access, transparency, and publication of reviewers’ names with published articles signals the timely democratization of the publication process, the concomitant “bot-tification” of the process was a learning curve for several Communication scholars–us included.

As we conclude this editorial, the United States has more than 13 million confirmed cases of COVID-19, and some estimates suggest that the death toll might reach 5,00,000 by the summer of 2021. Debates around masks, vaccines, technology transfers, economic impacts and racial and income inequalities related to the pandemic continue, painfully demonstrate the need for more research in how mechanisms of power/control/inequality shape individual and collective experiences of health and illness.

AUTHOR CONTRIBUTIONS

All authors listed have made a substantial, direct, and intellectual contribution to the work and approved it for publication.

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CONCEPTUAL ANALYSIS
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Critical Health Communication Methods at the U.S.-Mexico Border: Violence Against Migrant Women and the Role of Health Activism

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This essay re/envisions what critical health communication methods look like on the U.S.-Mexico border in reproductive justice contexts. For example, traditional health communication theories and methods have privileged objectivity, generalizability, and the creation of critically important health communication patterns and concepts that have guided the development, deployment, and execution of health communication programs and cultural competence programs. However, in this article, we discuss the utility and application of an intersectional/critical health communication reproductive justice method and envision its praxis in contexts like the U.S.-Mexico border. As two Chicana feminist reproductive justice/health communication scholars, our own research on reproductive feminicides throughout the U.S. and Latin America has necessitated the blending of a variety of theoretical and methodological approaches—border theories, intersectionality, Chicana feminisms, and health communication theories and methods. Thus, this essay traces the blending of these theories and methods and discusses how critical intersectional feminist health communication methods can be utilized in activist ways to resist reproductive and gendered violence at the U.S.-Mexico border.

Keywords: critical health communication methods, intersectionality, Chicana feminisms, reproductive justice, gendered violence, U.S.-Mexico border

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This essay re/envisions what critical health communication methods look like on the U.S.-Mexico border in reproductive justice contexts. For example, traditional health communication theories and methods have privileged objectivity, generalizability, and the creation of important health communication patterns and concepts that have guided the development, deployment, and execution of health communication programs and cultural competence programs. However, in this article, we call for broader, more intersectional approaches to study reproductive and gender violence in health contexts and discuss the utility and application of an intersectional/critical health communication reproductive justice research theory and method. We also envision its praxis in contexts and locations such as the U.S.-Mexico border. As two Chicana feminist reproductive justice/health communication scholars, our own research on reproductive feminicides and violence against women throughout the U.S. and Latin America (Hernández and De Los Santos Upton, 2018, 2019; De Los Santos Upton, 2019; Gutiérrez-Perez and Hernández, 2019; Hernández, 2019) has necessitated the blending of a variety of theoretical and methodological approaches in order to most thoroughly investigate the topics at hand—border theories, intersectionality, Chicana feminisms, and health communication theories and methods.

Thus, this essay traces the blending of these theories and methods and discusses how critical intersectional feminist health communication methods can be utilized in activist ways. In other words, what can the blending of intersectional feminist methods and health communication methods bring to the proverbial table when considering border activism as a means to disrupt traditional health communication theories, frameworks, and approaches to studying culture and violence against women? By discussing the blending of our research, our activist work, and our lived experiences with activist organizations and birth centers in California and Texas, we analyze how critical intersectional health communication research methods can work in tandem with social justice activism to illustrate the application of critical health communication research praxis to eradicate violence against Latin American migrant women's bodies, a most pressing global public health epidemic (World Health Organization, 2013). First, we provide a brief overview of migrant rights violations occurring at the U.S.-Mexico border. Then, we discuss current limitations of health communication approaches in a context such as the U.S-Mexico border and consider how a blended intersectional/reproductive justice/health communication method could serve as a puzzle piece within a sea of larger approaches to understand how we as scholars can utilize our positionalities and tools to both assist and resist at the border.

THE U.S.-MEXICO BORDER: MIGRANT RIGHTS VIOLATIONS AND VIOLENCE AGAINST WOMEN

Over the past several years, news discourses, immigration lawyers, immigrant rights advocates, and activists have both documented and lamented migrants' rights violations transpiring at the U.S.-Mexico border. Within this homeland security state (De Genova, 2007; Gonzales, 2014), Latinos and other individuals of color are subjected to the racial gaze of government officials who view individuals of color, particularly migrants of color, as perpetual suspect foreigners (De Genova, 2007; Gonzales, 2014; De Genova and Tazziolo, 2015). The homeland security state, first symbolically consolidated in the aftermath of 9/11, is defined as a national security state that has roots linking to specters of Communism at the Outset of the Cold War and now focuses on migration control (Gonzales, 2014; De Genova and Tazziolo, 2015) through whatever means are necessary to subdue migrants and attempt to close borders. During the Obama Administration, border patrol agents utilized pepper spray against migrants when an altercation ensued (Haltiwanger, 2018). Critics of the Obama Administration's stance on immigration have compared the Obama and Trump Administrations' immigration policies as "not night and day, but rather shades of gray," given that immigrants were placed in detention camps during the Obama Administration as well (Villalobos, 2011). As De Genova (2010) asserts, the assumption that the election of then-President Obama would remedy the immigration violation excesses of the Bush Administration "must be tempered by a sober assessment of the deeply consequential institutionalization of antiterrorism as the intransigent idiom of a new species of security state formation" (p. 613).

In the United States, in other words, the last few presidential administrations have presented for immigrants what De Genova (2009) refers to as "an ever more dismal horizon of rightlessness," with the Obama Administration's aggressive forms of border enforcement, workplace raids, and penalties for employers who hire immigrants now compared to the Trump Administration's violence policies on child detainment, migrant abuses, and family separation (p. 445). Migrants often occupy a precarious position: "They live in overcrowded houses and are subject to abuse and exploitation by employers in shady economies and denied access to education and health care. Furthermore, fearful of detention and deportation, they are susceptible to stress and anxiety," among other violences (Basok and Rojas Weisner, 2018, p. 1274). Mexican immigration in particular and Latin American immigration by extension has been rendered "synonymous with the US nation-state's purported 'loss of control' of its borders," thus contributing further to the American institutional intensification of militarized control (De Genova, 2004, p. 177). As Kovic and Kelly (2017) note, contemporary security policies produce and enact violence upon migrants in powerful and problematic ways:

> Rather than being protected by the state security apparatus, migrants are targets of security forces and policies in both Mexico and the USA. Facing structural violence in their sending countries and unable to obtain visas to legally cross Mexico, let alone a visa to legally enter the USA, working poor migrants do not enjoy the protection from risk and danger promised by security, instead they confront the security of violence.2 That is, the policies ostensibly designed to safeguard those living in the USA cause the violence that Central American working poor migrants almost certainly face in attempts to reach the USA. (p. 2)

Within the context of immigration from Latin America, The Trump Administration's migrant violations include but are not limited to the following: migrant adults and children have been kept in cages (Barry, 2018; Raff, 2018), migrant children have been both physically and sexually abused (Honarvar, 2018; Neuman, 2018), migrants have been forced to sleep under bridges because cages and detention centers have reached full capacity (Romero, 2019), and migrant women have been sexually abused, with no concrete understanding of just how many migrant women have been assaulted while on their journey or upon arriving at the U.S.-Mexico border. As Fernandez (2019) describes:

> On America's southern border, migrant women and girls are the victims of sexual assaults that most often go unreported, uninvestigated and unprosecuted. Even as women around the world are speaking out against sexual misconduct, migrant women on the border live in the shadows of the #MeToo movement. The stories are many, and yet all too similar. Undocumented women making their way into American border towns have been beaten for disobeying smugglers, impregnated by strangers, coerced into prostitution, shackled to beds and trees

> and — in at least a handful of cases — bound with duct tape, rope or handcuffs. (para. 4–5)

Although there are more than 100 documented reports of sexual assault of undocumented women along the border in the past two decades, law enforcement officials and immigrant rights advocates note that this number barely scratches the surface of the true violence epidemic at hand (Fernandez, 2019), suggesting that sexual violence is an inescapable component of the "collective migrant rights journey" (Fernandez, 2019). Moreover, from a reproductive justice rights violation perspective, babies have been ripped from their mothers' chests while breastfeeding (Barnes, 2018), migrant women's periods have been tracked against their knowledge and consent so as to prevent abortions (Anwar, 2019), migrant women have experienced stillbirths and miscarriages while detained because of restricted healthcare access (Gonzales, 2019), migrant children have been transferred to the foster care system with no plan for reunification (Lind, 2019), and, echoing centuries of racist, nativist governmental policies, families were separated with no plan for reparation or reunification. Women who have sought to relocate their children are provided with no resources *or* are provided with incongruent information, resulting in reunification efforts that span months (Stillman, 2018).

The "zero tolerance" policy instituted by the Trump Administration explicitly supported family separation as a government policy and enforced it under drastic measures (Lind, 2019). Within 2 weeks of the policy implementation, over 650 children were separated from their families and placed in detention centers with no notification to parents about their children's whereabouts (Barnes, 2018). Although a federal judge in June 2018 ordered the Trump administration to halt migrant family-child separation and reunite children with their families, at least 250 parents were separated from their children after the ruling. This estimate does not include siblings and other family members that have also been separated, leading experts to believe that the number is much higher (Lind, 2019). Representative Alexandria Ocasio-Cortez stated that outgoing homeland security Kirstjen Nielsen "oversaw one of the largest-scale human rights violations in recent history" (Jativa, 2019). Migrant family separation is "another cog in the historical American machine of racist, assimilationist policies that have separated children of color—black children, Native American children, and Mexican children—from their families over the past several centuries" (Hernández, 2019, p. 3). In this particular moment, family separation is a new iteration of the United States' fear of women of color's reproductive capabilities because of fears of demographic change (Love, 2018; Serwer, 2018), particularly when it is historicized within the forced sterilization of Mexican, Native, and black women over the past several centuries in the United States (Roberts, 1999; Gutiérrez, 2009; Gutiérrez and Fuentes, 2009; Lira and Stern, 2014). In other words, "America has created psychological trauma by abducting and imprisoning children, and separating families for their race, color and nationality" (Love, 2018, para. 2). Furthermore, overshadowing a potentially grimmer future, when asked about Nielsen's departure, Nancy Pelosi replied, "It is deeply alarming that the Trump administration official who put children in cages is reportedly resigning because she is not extreme enough for the White House's liking" (New York Times, 2019).

From a reproductive justice and gender violence perspective, the aforementioned violences against migrant women and children are representative acts of what we understand to be reproductive injustices, reproductive feminicidios that highlight the oppressive, violence circumstances surrounding Latin American migrant women's abilities to provide safe spaces for their children, prevent further acts of violence, and keep their families together (Hernández and De Los Santos Upton, 2018). Furthermore, the term "reproductive feminicidio" highlights the gendered nature of this violence against Latin American women in reproductive spheres (Hernández and De Los Santos Upton, 2018). In other words, as we discuss in more detail later in this article, reproductive violence against women occurs not only through restrictions of women's rights during pregnancy; rather, from a reproductive justice perspective, acts such as child abuse, maternal abuse, and mother-child separation with no plans of reunification constitute larger reproductive injustices that highlight the gendered nature of violence, the stripping of women's choices and safety in both reproductive and maternal contexts, and institutional and structural limitations and barriers that endanger women and their children in the most dire of circumstances (Hernández and De Los Santos Upton, 2018; Hernández, 2019). As Guidotti-Hernández (2011) illustrates, violence orders an analysis of gendered, classed, racial, and sexual inequalities and renders visible the relationships between national politics and the treatment of citizen and immigrant bodies. In other words, if the meaning of gender violence depends on the gendered identities of the parties (Engle Merry, 2009), then in this context, we are concerned with the treatment of women migrants, their children, and the reproductive injustices occurring at the U.S.-Mexico border.

From a rhetorical and discursive perspective, news and popular discourses surrounding migrant rights and the "caravan" have ebbed and flowed between understanding the need to migrate as a requirement for survival versus a national security threat. From the perspective of survival, "the United States government under the Trump administration is enacting legal policies to sanction family separation and maternal/child abuse while simultaneously evading its hand in spearheading wars throughout Latin America that necessitated the need for asylum seeking in the first place" (Hernández, 2019, p. 1). Wars that were supported by the United States government in Guatemala, Honduras, and El Salvador directly facilitated the need for migrants to seek refuge and safety (Villeda, 2012; Baker Jordan, 2018; Hernández, 2019). In this moment, the "intertwining of geopolitical, geospatial, and colonialist actions illustrates how institutional, societal, and political structures across borders caused political unrest and economic collapse that necessitated the quest to find asylum" (Hernández, 2019, p. 1). From the perspective of a national security threat, Hannity (2018), for example, described it as a "border crisis":

> Now, for weeks, we've been warning about the looming crisis out of the southern border, now at least 5,000 migrants have already

> arrived in the Mexican border city of Tijuana with thousands more still on the way. But over the weekend, we saw several hundreds of these so-called asylum-seekers, look at what they're doing, they are rushing the U.S. border. They are hurling rocks, bottles, other objects over the fencing. Three border patrol officers were struck. We have broken windows, damaged vehicles of border patrol in order to protect the border themselves, U.S. Border Patrol agents fired non-lethal tear gas to disperse the mob of migrants trying to break across by force.

As scholars assert, rock throwing is a weapon of the weak (Scott, 1985), one that has long justified retaliation and even lethal violence on behalf of Border Patrol agents against migrant bodies (Galvan, 2018; Chávez, 2019): "The rock throwing is a trope, a dog whistle to white nationalists. … In Trump's view, the slow-moving caravan of tired and weary people is itself weaponized, a mortal threat that must be extinguished by any means necessary" (Chávez, 2019, p. 14).

This "threat" and "crisis" is, however, manufactured politically. For example, in the fall of 2018 Customs and Border Protection Agents began using a process called "metering," which involved standing in the middle of international bridges in El Paso/Juárez, holding semiautomatic rifles and preventing migrants from stepping foot on U.S. soil to legally claim asylum in an effort to limit to number of asylum seekers allowed to enter the U.S. on any given day (Moore, 2018a, 2019a). This practice left hundreds of migrant families, many with young children, camping out on international bridges to avoid losing their places in line. On Christmas Eve 2018, Immigration and Customs Enforcement Officials released over 200 asylum seekers into the streets of downtown El Paso, leaving them without food, money, or transportation, causing non-profits and community members to quickly mobilize to create temporary shelters and provide warm meals (Moore, 2018b; De Los Santos Upton, 2019; Sowards, 2019). Most recently, U.S. Customs and Border Patrol created a temporary "holding pen" underneath an international bridge in El Paso where asylum seekers were harassed, treated like "animals," left untreated for illnesses, forced to wake up and stand every 3 h, and where children's bodies were bruised from sleeping on rocks (Da Silva, 2019; Moore, 2019b). These three events in El Paso and Juárez were extensively photographed and filmed, and the resulting footage was widely shared to create a media spectacle, which Trump and his supporters used to bolster their claims of a crisis at the border.

From a reproductive justice and migrant rights perspective, the border crisis we are concerned with is the problematic treatment of migrants and the separation of families. Although some popular discourses frame the U.S-Mexico border, as we mentioned earlier, in problematic ways to incite national hysteria toward Latin Americans as "illegals," "drug dealers," and "rapists," other perspectives illustrate how the migrant caravan is a space for coalition building, safety, and security. As Chávez (2019) notes, the coalitional nature of the migrant caravan provides both physical safety and financial security—safety from environmental and physical assaults and mobility without a guide or coyote. However, the true danger of the migration occurred not *during* the migration but upon arrival at the U.S.-Mexico border when the caravan was disbanded and re-rendered as deportees or detainees, "marked as best for expedited removal and at worst for death":

> Roxsana Hernandez, a 33-year-old, HIV-positive transgender migrant from Honduras, arrived safely at the Mexico–US border in May. Immediately taken into detention, within a month, she died in Immigration and Customs Enforcement (ICE) custody from what can only be described as medical neglect. Once confined as an individual, the coalition no longer has power. (Chávez, 2019, p. 12)

Moreover, Johana Medina, a migrant transgender woman from El Salvador, died in a Texas hospital after being criminalized and denied medical care. Her death in migrant custody raises several questions about the larger pattern of systemic abuse by Immigration and Customs Enforcement (ICE) agents against LGBTQ migrant asylum seekers (Vasquez, 2019b), as journalists reported that ICE's statement on Medina's death used her dead name, perpetuated problematic narratives about transgender individuals, and parroted false claims about how certain individuals "bring unknown diseases" into the country (Vasquez, 2019b, para. 5). Hernandez's murder and Medina's death are but two examples of the gendered violence occurring at the border transpiring in tandem with other gendered and reproductive injustices, which is what inspired the origins of our intersectional/critical health communication reproductive justice method.

LIMITATIONS OF CURRENT HEALTH COMMUNICATION APPROACHES IN A BORDER CONTEXT

The health communication sub-field has provided valuable research on health behaviors, health experiences, health barriers, health outcomes, and health interventions and campaigns, to name a few. However, health communication methodological approaches are oftentimes post-positivist in nature, which ontologically and epistemologically are not thoroughly equipped to study migrant lived experiences of the injustices transpiring at the border *or* of the impacts of the historic, racialized, systemic injustices in shaping one of the largest human rights violations in the United States in recent years. As we discuss in greater detail later in the essay, in order to attend to both migrant and reproductive justice, critical health communication methods should include intersectionality, border theories, and health communication theories, and methodological approaches should attend to historical foundations of the current crisis at the border and involve praxis. This is not to say, however, that health communication has no critical roots. Foundational scholars such as Beltrán (1995, 2004, 2006, 2010), Figueroa et al. (2002), Kincaid and Figueroa (2009), and Storey and Figueroa (2012) have provided critically important frameworks to help scholars and practitioners understand the relationship between communication and social change. Beltrán's (2006, 2010) works, for example, have analyzed social change and development within the context of U.S.-Latin America relations.

Viewing communication as a vehicle for social change, Beltrán (2010) defined health communication as a social process, a professional exercise through the systematic use of media, and as a transformation agent, an educated commitment dedicated to improving health for generations to come. Moreover, health communication can become transformative by being both cooperative and empowering, by allowing communities to intervene in decision making pertaining to development services and also empowering communities to become major partners in their healthcare program development and execution (Beltrán, 2010). Similarly, building upon the work of Freire (1970) who viewed communication as an important vehicle for social change, Figueroa et al. (2002), Kincaid and Figueroa (2009), Storey and Figueroa (2012) envisioned new connections between social development and global health communication, acknowledging that the evolution of new global public health concerns has necessitated aspirations toward a global theory of health communication (Storey and Figueroa, 2012).

Although these important scholarly and applied conversations are developing as we speak, with practical international applications across the globe, over the past 5 years, however, scholarship about Latina/o/x and Latin American populations in top health communication journals have largely utilized post-positivist methods to explore Latina/o/x and Latin American health, and virtually no research in top health communication journals has explored health issues and violence (as a public health concern) at the U.S.-Mexico border. Communication research on this topic, rather, is largely published in journals such as *Women's Studies in Communication* and elsewhere (Holling, 2014; Chávez, 2017, 2019; Flores, 2017, 2018; Lechuga, 2017; Lozano, 2018).

For example, Hernández and Martinez (in press) conducted a systematic review of representations of Latina/o/x and Latin American populations in top health communication journals from 2014 to 2019 and found that Latina/o/x and Latin American populations were present in a staggering 14% of health communication journal articles over the past 5 years ($n = 257$ out of 1,850 articles total). From a sample perspective, Hispanic, Latina/o/x, and Latin American populations were the focus of 21% of all studies across health communication journals. At the outset, this percentage might appear to be slightly positive. However, further analysis revealed that Hispanic, Latina/o/x, and Latin American populations comprised 0–5% of the article/study sample in 31.5% of all studies across health communication journals. In other words, although Hispanic/Latino populations were present in these studies, their presence was marginal, given that they comprised less than 5% of the study sample. Moreover, out of all the articles published in top health communication journals that included Latina/o/x and Latin American populations, out of the 257 articles across journals, studies were mostly quantitative, with 53% of studies utilizing surveys and 21% of studies utilizing experiments. Qualitatively, only 10.5% of studies utilized in-depth interviews, and 9% of studies utilized focus groups. Survey and experimental methods could indeed provide valuable insights about different angles of the current health catastrophe occurring at the U.S.-Mexico border, but they fail to capture, critique, and interrogate the larger systemic, national, colonialist, and xenophobic factors that facilitated these violations in the first place. Although we acknowledge that this may not be the overt goal or approach of quantitative methodological approaches, in a context such as this, such an approach to historicization and deconstructing power relations is needed more than ever.

We contend that reproductive and gender violence at the U.S.-Mexico border is indeed a health communication topic because of the colonialist violence, abuse, assault, and poor living conditions that (a) shaped the need to migrate for asylum and (b) shape the physical and reproductive injustices at detention centers and cages at the border. As such, we have called elsewhere for stronger theoretical and methodological collaborations between health communication scholars, Latina/o communication studies scholars, border scholars, and those of us who find ourselves located in the nepantla space between and betwixt theories and methods (De Los Santos Upton, 2019; Hernández and De Los Santos Upton, 2019). This kind of collaboration could lend valuable insights and applications for, say, a health communication campaign or intervention to improve health outcomes for migrants at the border, to break down language and literacy barriers, and/or to assess whether promotoras or other community/cultural liaisons could be employed to act as health advocates for migrants experiencing health crises, mental health issues, stillbirths, and other reproductive injustices that we outlined at the outset of this article. These types of approaches would benefit from both theoretical and methodological crystallization, as together they could combine a critical historicization of the abuse with both quantitative and qualitative methodological approaches to break down barriers to better health access and advocate for migrant rights and safety during this vulnerable time.

Hernández and Martinez (in press) also found that, topically, over the past 5 years, health communication research that either focused on Latina/o/xs specifically or included them in the sample mostly focused on health contexts such as tobacco use, healthy eating, weight management, diabetes, patient-provider communication, and health literacy. There is a silence in health communication journals about these reproductive and gendered violence injustices. Although we acknowledge that research could still be in the pipeline or revision process, this raises valuable questions about (a) whether scholars doing this research feel that health communication journals are appropriate for this topic and also receptive to their research, and (b) whether scholars feel that their research might be better received elsewhere. Latina/o communication scholars such as Holling (2014); Flores (2017, 2018); Chávez (2017); Chávez (2019); Lozano (2018); and Lechuga (2017) have addressed gendered violence at the border, yet their research has been published in *Departures in Critical Qualitative Research* and *Women's Studies in Communication.* Health communication scholars are uniquely positioned to address health injustices occurring at the border, particularly those who live in border states. The reproductive and gendered violences transpiring at the U.S.-Mexico border demonstrate the urgency for health communication, Latina/o/x communication, and border studies scholars to (a) make sense of the complex web of historic, colonialist, misogynistic, and xenophobic factors that created the context for this violence, and (b) work together to utilize our tools and training to protect migrants in their most vulnerable state.

OUR APPROACH: AN INTERSECTIONAL/CRITICAL HEALTH COMMUNICATION REPRODUCTIVE JUSTICE METHOD

We contend with Chávez (2019) that we take seriously our limitations to both understand and intervene in a context such as this, acknowledging our place privilege as U.S. citizens, insider/outsiders at the border (Hernández and De Los Santos Upton, 2019) in our home state of Texas, who utilize a critical eye to interrogate the racist, nationalist, and misogynistic undercurrents of migrant abuse. Thus, this approach is not a complete solution to the migrants' rights crisis at the border, but rather a space for us to consider how a blended intersectional/reproductive justice/health communication method could serve as a puzzle piece within a sea of larger approaches to understand how we as scholars can utilize our positionalities and tools to both assist migrants and resist injustice at the border.

In previous research we and others have argued that family separation and migrant violence is reproductive injustice (De Los Santos Upton, 2019; Hernández, 2019) and that reproductive justice can only be achieved when equitable and supportive healthcare is a reality for women of all backgrounds, including the ability and freedom to make their own informed decisions about whether or not to reproduce, free from intervention (Ross et al., 2016; Ross, 2017; Ross and Solinger, 2017; Hernández and De Los Santos Upton, 2018, 2019). By extension, for women who do choose to have children, reproductive justice also includes the right to carry, birth, and raise children in safe cities free from toxic, environmental, and legal/governmental pollutants and intervention. Women at the border are currently being denied the right to access safe, legal abortion, receive the prenatal and postnatal care they need, birth in supportive environments, and ensure they are able to stay with, protect, and raise their children. We therefore argue that family separation and reproductive injustice is an extension of *reproductive feminicide* (De Los Santos Upton, 2019; Hernández, 2019), which is an act of gendered violence against women on the reproductive spectrum, spanning from a structural limitation of reproductive options to the murdering of women because of their reproductive capabilities (Hernández and De Los Santos Upton, 2018).

To more thoroughly understand the scope of migrant rights violations at the border from a reproductive justice perspective, we realized we needed a critical health communication method informed by several approaches: intersectionality, border theories, *and* health communication theories (Hernández, 2019). In addition to reproductive justice, the second theoretical strand that informs our methodological blending is intersectionality. Communication and feminist/gender studies scholars have contributed literature and research that explores the intersection of gender violence (Holling, 2014; Lozano, 2018), communication, and reproductive justice (Hernández and De Los Santos Upton, 2018; De Los Santos Upton, 2019), a combination of identity and gendered factors that necessitates a stronger, more complex theoretical approach. Intersectionality is one such tool that is useful this context. As we mentioned earlier in this article, as Guidotti-Hernández (2011) illustrates, violence orders how we analyze classed, gendered, racial, and sexual inequalities. Moreover, gender violence theories render visible the relationships among national politics, citizenship, and the actions that support violence against bodies and individuals (Hernández and De Los Santos Upton, 2018). Thus, in this context, intersectionality helps us understand more clearly and more thoroughly how violence intersects with race, gender, class, sexuality, and nation to facilitate crises such as those occurring at the U.S.-Mexico border. As we have noted in past research, "the inclusion of intersectionality and reproductive justice as theoretical lenses highlights how connected structures such as politics, government actions and policies, and national and international conflicts form a constellation of effects and outcomes on migrant women's bodily autonomy and reproductive rights" (Hernández, 2019, p. 2).

Rooted in black feminisms and critical race theory, intersectionality attends to the unique identity categories at play in shaping women of color's experiences from racial, gendered, ethnic, sexuality, and nationality identity points, among others (Crenshaw, 1991). At its core, in Crenshaw's (1991) earlier research, intersectionality "highlighted the ways in which social movement organization and advocacy around violence against women elided the vulnerabilities of women of color, particularly those from immigrant and socially disadvantaged communities" (Carbado et al., 2013, p. 303). Intersectionality "attends to both the ways that categorization has facilitated and rationalized social hierarchy and to the institutional and societal structures that have come to reify and reproduce social power" (Bello and Mancini, 2016). In other words, violence against women cannot be fully understood and conceptualized unless it is understood from a matrix that interrogates the outcomes of racism, sexism, and classism, to name a few (Hernández, 2019). As Crenshaw (1989, 1991) so aptly illustrated, interventions that seek to provide assistance to women of color dealing with violence and discrimination will fall short if using the same intervention approaches used for women of other racial or ethnic backgrounds. In the context of violence against migrant women at the U.S.-Mexico border, this ultimate takeaway from Crenshaw's (1991) research is one of the driving forces underlying the need for a new methodological approach to study and resist violence against women. This does not mean, however, that we should resist coalitions with other groups. To the contrary, Crenshaw (1991) asserts:

> In the context of antiracism, recognizing the ways in which the intersectional experiences of women of color are marginalized in prevailing conceptions of identity politics does not require that we give up attempts to organize as communities of color. Rather, intersectionality provides a basis for reconceptualizing race as a coalition between men and women of color. For example, in

> the area of rape, intersectionality provides a way of explaining why women of color have to abandon the general argument that the interests of the community require the suppression of any confrontation around intraracial rape. (p. 1299)

Moreover, as Ross (2017) notes, in the spirit of the Combahee River Collective, reproductive justice activists have long utilized intersectionality as a guiding theoretical frame to shift reproductive politics and articulate "our demand for recognition of our full reproductive and sexual human rights" (p. 287). By moving past the pro-life/pro-choice binary that consistently characterizes reproductive rights discourses (Hernández and De Los Santos Upton, 2018) and by considering the intersections of racism, sexism, xenophobia, and classism, we can more thoroughly interrogate the factors that facilitate reproductive migrant rights violations at the U.S.-Mexico border. In other words, as we mentioned earlier in this manuscript, considering the intersections of racism, sexism, and classism historicizes and contextualizes family separation as not merely a migrant detention tool, but rather a violation of human rights that facilitates the legal separation of migrants from their newborns, the return of mothers to criminal custody, and the further erosion of Latin American families at the U.S-Mexico border (Vasquez, 2019a). In this article, we assert that reproductive justice *is* a valuable health communication framework when approached intersectionally, as it necessitates an understanding of how systemic factors have contributed to health violations and detrimental health experiences for traditionally marginalized groups.

As such, the third and final strand in our critical health communication methodological approach is border studies. For outsiders looking in, borders are often viewed as strict lines of division that neatly and clearly separate two territories. For those of us who inhabit borders, we know that rather than existing as strict lines of separation, borders create borderland spaces and communities that are overlapping, ambiguous, and contested. These borderlands are not just physical, they also emerge "wherever two or more cultures edge each other, where people of different races occupy the same territory, where under, lower, middle and upper classes touch, where the space between two individuals shrinks with intimacy" (Anzaldúa, 2007, p. 19). Anzaldúa (2007) argues that borders are also psychological, spiritual, and sexual, as borderlands emerge when artificial binaries are constructed between genders and sexualities (i.e., gay/straight, male/female), and through efforts to rigidly define and delineate the secular from the sacred. People who exist in these in-between spaces therefore develop a "tolerance for ambiguity" known as "mestiza consciousness" (Anzaldúa, 2007, p. 101).

As Chicana feminist scholars from Texas, our methodologies are also informed by the various borders we inhabit. Anzaldúa (2015) explains that those living in the in-between space of the borderlands may choose to embrace a nepantla identity, characterized by the ever shifting, breaking, and rebuilding of identity that is sometimes necessary to maintain a sense of self as we straddle multiple languages, cultures, countries, and ways of being in the world. We are also equipped to attend to the historical state of border militarization, and bear witness to how this militarization impacts lived experiences of the border today. Inhabiting this space of nepantla uniquely positions fronterizxs to engage in activism that moves beyond borders and binaries, enabling us to form alliances and build coalitions across multiple issues such as migrant and reproductive justice (De Los Santos Upton, 2019). As scholars existing in a space of nepantla, we also find it necessary to move beyond disciplinary limits and boundaries to blend methodologies that are meaningful for the topics we choose to research.

WHAT DOES THIS LOOK LIKE IN PRAXIS?

As health communication scholars interested in reproductive justice and activism, it is important to keep in mind that the personal is always political. As black feminists have long noted, black motherhood is inherently always political, because in caring for children and raising them, we cannot simply accept the world as it is (Ross, 2017; McClain, 2019). Thus, in this same vein, we operate from the understanding that motherhood for women of color is always political particularly because of our current political, racial, and cultural climate. In previous research we have explored the ways in which our positions as mother and tía fuel "our commitment to reproductive justice in all spheres" (Hernández and De Los Santos Upton, 2019, p. 1), and we are not alone. For example, the group "Angry Tias and Abuelas of the Rio Grande Valley" are dedicated to providing humanitarian aid to migrants arriving at the Mexico-U.S. border. This aid ranges from providing needed items such as food, water, diapers, and sanitary napkins, to sitting one-on-one with migrants to go over bus routes, inform them about border checkpoints, and explain taken-for-granted information like the availability of free bathrooms and water fountains in public places (Molinari, 2019). These actions, both big and small, contribute to reproductive justice by providing items necessary for reproductive health and supporting individuals and families in their paths to create lives for themselves in the United States.

As we make our own choices about reproductive health we have, when possible, chosen to access services in spaces that work at the intersections of migrant and reproductive justice. For example, at the time of this writing Sarah is accessing prenatal healthcare with a birth center in El Paso that specifically works to make culturally appropriate, empowering prenatal and postnatal care, as well as birth services accessible to women in El Paso, Texas and Ciudad Juárez, Chihuahua. For example, the center holds a variety of birth and parenting workshops and classes in El Paso and Juárez, and midwives play a major role in ensuring women in this border community are able to birth in ways that allow them to feel empowered and respected, including helping to facilitate crossing the international border to birth. The center where she receives free breastfeeding support services also works at these intersections, continuously collecting donations for the most needed items at migrant shelters in El Paso and creating opportunities for the mothers accessing these services to play a role in addressing the migrant crisis in El Paso. Healthcare workers in both these spaces regularly organize and engage in activist efforts around migrant and reproductive justice on the border, and for Sarah, choosing to enter these spaces for her own reproductive healthcare needs was ultimately a political choice that has allowed her to organize with other mothers and make meaningful connections that work to facilitate her own activism and scholarship. These health centers inform our understandings and definitions of reproductive justice, and in future research we will explore their cultural methods of care and birth as examples of health activism. Moreover, Leandra has been an active member of several reproductive justice organizations in California and Texas. By attending meetings and protests, developing community engagement coalitions, assessing community health needs and barriers, donating items and assistance to migrant communities near the border, and lending research services, she has been able to develop community partnerships and apply her methodological tools to work toward better health outcomes for local communities and migrant communities. Our experiences demonstrate how the decisions that we make, including where we access healthcare, what we study, and who we partner with in our research and activism, exist on a spectrum of reproductive justice that ranges from small, everyday acts, to more large-scale activists efforts, and each of these is interconnected. As scholars, given our training and expertise, we are uniquely positioned to assist where help is needed most. We can and should use our tools to both assist marginalized groups and resist interlocking webs of oppression, sexism, classism, and racism.

There are also several qualitative methodological tools that can be utilized to engage in critical health communication activist work in contexts such as the U.S.-Mexico border. Such methods can transform research "for research's sake" or simply studying a topic, to being there, in the moment, fully offering one's services and help where it is needed most. We fully acknowledge that our methodological approach is taxing from an emotional labor perspective; however, as critical, intersectional reproductive justice scholars, the personal is always political, thus facilitating the need for such a methodological approach to praxis. As Ross (2017) asserts:

> Praxis is a term most often used by oppressed groups to change their economic, social, and political realities through social justice actions based on theoretical reflections. Reproductive justice praxis puts the concept of reproductive justice into action by elaborating the connection between activism and intersectional feminist theory. Activists intentionally employ a complex intersectional approach because the theory of reproductive justice is inherently intersectional, based on the universality and indivisibility of its human rights foundation. (p. 287)

First and foremost, from an intersectional perspective, scholars should seek to historicize the current state of the U.S.-Mexico border within the U.S.'s larger history of violence against families of color and women of color, as we have mentioned earlier in this article. Second, studies should interrogate the role of power in facilitating such violences. Operating within a critical feminist border and health communication framework, we contend with Lozano (2018) and Lockwood Harris (2018) that approaches to deconstructing and interrogating gender and violence must centralize the role of power and understand how it operates. As is stated in Lockwood Harris (2018):

> Meaningful efforts to sort out what is violent from what is less so must include an analysis of power. People with privilege routinely respond defensively— and sometimes violently—when marginalized groups insist on basic rights and autonomy. To acknowledge and validate the fear, shame, and anger that propels this backlash is important. It is also important to pursue critical questions about the structures from which societal emotion emerges (Cvetkovich, 2012, p. 114)

Her analysis provides a useful framework for understanding the social dimension of public backlash to migrants' basic human needs and acknowledges the societal emotion dimension of this larger human rights violation context. Moreover, Lockwood Harris (2018) asserts that "Acknowledging the realities of violence requires perpetrators and survivors alike to grieve a lost illusion of safety and security. Scholars of gender and violence can and should identify the practices that both dissolve individuals', communities', and organizations' denial about violence and also maintain their well-being" (p. 114). At both a micro and macro level, Lockwood Harris' (2018) approach to interrogating gendered violence/violent gender reminds us that we should consider how individuals deny violence as one of the predominant factors that enables such violence to continuously occur. Citing Madison (2012), she notes:

> Witnesses to violence—not mere onlookers—have the capacity to bear wounds of responsibility. They are able to notice violence without being victimized, but they also are not apathetic. To theorize gender and violence responsibly requires researchers to balance two sides of aversion: avoidance and despair. Scholars must not only assert the horrors of violence but also provide a map for a world with more complete justice, stronger communities, and collective psychological resilience. (p. 114)

Third, to move from being mere onlookers to true witnesses, we must pay attention to the ways narratives about violence on the border are constructed, as well as how we position ourselves as (potential) witnesses. For example, recounting a trip with students to Ciudad Juárez, Holling (2014) demonstrates that by sharing space with the sister of a victim of feminicidio, and listening to her feminicidio testimonio, her students were transformed from simply being listeners to becoming witnesses. This witnessing ultimately led them to engage in activism around the issue of feminicide. When emotional responses to violence are coupled with possibilities for action, we are positioned to bear witness in ways that produce conocimiento (Anzaldúa, 2015), or a transformative awareness which involves imaginal, spiritual-activist potential (Hernández and De Los Santos Upton, 2018). As educators, scholars, and researchers, particularly those of us in the borderlands, we should remain cognizant of how we are witnesses to violence discursively and physically, those of us who have the place privilege (Chávez, 2019) to witness border violence atrocities without being directly affected. It is times like these that require our action the most.

Fourth, scholars could explore the discursive, the material, and the interplay between the two. In addition to frameworks that emphasize societal emotions and collective psychological resilience, Lozano (2018) presents border materialism as an additional framework that can be utilized in collaborative research, which "offers scholars and activists a lens to examine how women's bodies, neoliberal logics, and geography intersect and function to give rise to and perpetuate global acts of feminicidio. Border materialism helps us understand how feminicidio is enabled, normalized, and perpetuated through mutually reinforcing material and cultural practices" (p. 105). As a scholar and activist, Lozano has utilized border materialism to explain violence against women at the U.S.-Mexico border and as a platform for over 15 years of social justice activism. Her work involves the analysis of movement artifacts and archival documents, as well as public discourses she recorded at town halls, symposia, protests, marches, and rallies. As a scholar-activist, Lozano has participated in three formal delegations to Juárez, traveled with students to "listen, learn, and work alongside family members and activists in their struggles for justice against feminicidio," and engaged in protests against the Mexican government in the U.S. and Mexico (p. 10). Her ongoing scholarship and activism ultimately centers around the relationships she has built with Mothers[1], family members, and activists, and she has worked alongside them to paint crosses where the bodies of feminicidio victims have been found, paint a mural of Maria Elena, one of the disappeared, and participate in a rastreo, searching for victims' remains. Through these relationships, her rhetorical fieldwork privileges "co-presence" (De Onís, 2016) alongside community members, as her voice and body are present with Mothers and activists in Ciudad Juárez. While many scholars have conducted research around feminicidio in Juárez in ways that made families feel they were "profiting off their daughters' deaths," Lozano's approach is a "labor of love" and a "labor of political commitment" aimed at doing justice for family members, victims, and the movement itself (p. 11). Lozano's (2018) border materialism framework could be utilized in health communication studies to explain the geographic, economic and gendered histories and conditions that constructed material conditions at the border, which can then inform studies and interventions that seek to assist migrants and resist injustices. Her approach also reminds us that "it is critical that we, as 'experts,' defer to the community members or interlocutors that we are working with," (p. 12) as all scholarly and activist efforts should stem directly from the needs, desires, and/or goals of migrants themselves. Similarly, Doering-White's (2018) research that explored both violence and care along the Central American migrant trail through Mexico consisted of 2 years of ethnographic fieldwork with migrant shelters, individuals who are social workers, and non-recognized employees who provide care. Doering-White (2018) asserts that border materialism through an analysis of movement artifacts such as bandages, blisters, and the items that migrants leave behind and gather on their journey "complicates ideas about agency and objectification that surround marginalized populations who may not be in a position to verbally contextualize their current predicament" (p. 435).

Fifth, approaching critical health communication research on the border requires a sensitivity to the experiences of migrants as a marginalized group, as Ojeda et al. (2011) remind us that "Research can either support or harm communities. Thus, researchers should develop the cultural competencies to conduct research with the Latino immigrant population" (p. 2). For example, because research methodologies are often developed based on U.S. cultural norms, common procedures such as obtaining informed consent can be difficult to navigate as migrant populations may be reluctant to sign forms they view as putting their immigration status in jeopardy (Lu and Gatua, 2014). Migrant populations are often characterized as vulnerable and in need of protection during the research process; however, they are also capable and competent, and to focus only on their vulnerability is a form of otherization (Lahman et al., 2011). In their work with undocumented participants during the passing of SB 1070 in Arizona, Lahman et al. (2011) explain: "While we agree sensitivity to vulnerability is vital to ethical research, we believe it is important to remember that someone who is vulnerable in one context might be powerful in another" (p. 308). Drawing from Lahman et al. (2011) to consider how culturally competent research should be pursued at the intersection of migrant and reproductive justice, we contend that researchers and activists must do the work to recognize the inherent strength and resilience needed to migrant during this "time of fear," while simultaneously working to protect participants through careful methodological considerations surrounding anonymity, confidentiality, and consent. In line with Dutta's (2008) culture centered approach, we echo these scholars' approaches by reinforcing the need to historically situate culture in our research and build health communication theories and methods from the experiential vantage point of cultural members.

Sixth, in addition to the commitment to do no harm during the research process, it is important to reflect on how the composition of a research team and the cultural knowledge they bring to the table will impact the experiences of participants. The objectivist approaches traditionally taken in quantitative health communication research run the risk of reinforcing borders within the research process by reinscribing us/them, nos/otros binaries between researchers and the researched (Saavedra and Nymark, 2008; Lahman et al., 2011). Additionally, while quantitative approaches in traditional health communication research often test existing theories, Ojeda et al. (2011) argue that qualitative research can instead generate theories directly from the experiences of Latino migrants. Offering guidelines for culturally competent research with Latino migrants, they argue that researchers should pay specific attention to the process, rather than just focusing on outcomes. Integrating cultural values based in personalismo, or the creation of interpersonal connections, culturally competent researchers can engage in plática (small talk), demonstrate respeto (respect), and work to develop confianza (trust) (Ojeda et al., 2011). To effectively

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[1] We have kept Mothers capitalized in accordance with Lozano's strategic use of capitalization.

integrate these cultural values, Ojeda et al. (2011) stress the importance of involving bilingual and bicultural researchers as members of the research team. They explain that it is also important for researchers to understand the context surrounding the migration process:

> "Researchers interested in learning about the Latino immigrant experience should acquire basic content knowledge regarding the immigration process of Latinos and their motives for migrating to the United States. This includes an understanding of participants' premigration, migration, and postmigration contexts, reasons for migrating to the United States, prior and current U.S. immigration policies, and the different types of immigrant statuses." (Ojeda et al., 2011, p. 5)

Similarly, critical health communication research and activism surrounding violence on the border should involve knowledge about the historical context surrounding current migration patterns, as well as remain up to date on current policies and practices affecting migrants at the border.

In conclusion, there are multiple ways to translate critical health communication methods into intersectional praxis at the U.S.-Mexico border. As critical health communication researchers, we should be strategic about our activism and scholarship, and find ways to live out our values surrounding reproductive justice in our communities. We must attend to the historical context surrounding migration and border militarization, and critically examine how these histories enable reproductive injustices. As scholars, activists, and community members we are also responsible for interrogating the ways in which power operates in bordered spaces and facilitates violence, and we should continue to reflect on our own roles as witnesses. It is thus important to consider the intersections of the material and the discursive and privilege the knowledges and experiences of the communities we work alongside. When working with any marginalized community, we have a responsibility to not only be sensitive to the harm research can cause and work to mitigate risk, but also avoid characterizing research participants as only vulnerable, thus denying their power, strength and resilience. Finally, by practicing cultural competence we can work with participants in ways that allow us to transcend binaries in the research process. We argue that in order to resist reproductive and gendered violence at the U.S.-Mexico border, a combination of these practices in critical health communication methods is urgent.

CRITICAL HEALTH COMMUNICATION METHODS MOVING FORWARD

In this article, we have described the migrants' rights violations transpiring at the U.S.-Mexico border, detailed some of the limitations of current health communication approaches to studying this type of violence, and discussed our methodological approach: an intersectional feminist reproductive justice health communication approach that was necessitated by reproductive and gender violence against migrant Latin American women and children. Moreover, we have noted several methodological, cultural, and epistemological considerations that scholars should acknowledge and implement when seeking to work with migrant populations. Ultimately, as health communication scholars, we find ourselves located within theoretical and methodological paradigms that are uniquely positioned to address health violations and gender violence. By combining several theoretical approaches—intersectionality, reproductive justice, and border studies—and by utilizing cultural methodological considerations, we can work to address gender violence, assist marginalized populations, and resist human rights violations at the U.S.-Mexico border.

AUTHOR CONTRIBUTIONS

All authors listed have made a substantial, direct and intellectual contribution to the work, and approved it for publication.

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CONCEPTUAL ANALYSIS
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Critical Health Communication Methods: Challenges in Researching Transformative Social Change

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This reflexive essay describes how methodological choices involved with critical commitments to understanding the economic and political roots of health status lead to challenges in the field that intersect with the politics of academic training, visibility, and publishing. Through the lens of my own research experiences, I discuss lessons learned as well as ways that I continue to struggle. I consider issues that are primarily personal and those that we should address as a field. In the essay, I describe six observations from my experiences researching transformative social change that have implications for critical health communication scholars and the discipline of health communication.

Keywords: critical health communication, qualitative methods in health communication, health communication and social change, health and the economy, health organizing

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I am taking notes as Secretary for the Board of Directors meeting for Apple Street Market, a worker and community-owned neighborhood grocery initiative. We are discussing the building committee's request for more information about our last-ditch efforts to obtain the funding we need to secure our site for the store. The building committee members discuss Request for Proposals from the site owner, variances from city ordinances, possible co-location with other businesses, sales estimates per square foot, and the intricacies of New Market Tax Credits. The next topic is our fundraising campaign, which has to address securities law as we consider owner loans, owner shares, and donations. As I take notes, I am wondering, how did I get here again?

I say "again" not only as a figure of speech but because this is not the first time that I have had this thought during this and other engaged research projects. I wondered about my research role with Apple Street Market when I was learning how to light chafing dishes for buffet lines at member-owner meetings. I wondered how having a Ph.D. in organizational and health communication led me to participate in a march with global trade justice protesters in downtown Cincinnati, wearing an orange arm band that indicated that I (all 5′ 3″ of me) was a marshal—keeping folks in line with the parade parameters we had negotiated with the police—all while carrying a notebook instead of a protest sign. For good measure, we got tear gassed by Cincinnati police officers when the event was completed and the police had already towed my car at another event earlier that week.

In this essay, I first describe how my research agenda led me to these engaged research experiences. Although much has been written about participatory and community-engaged research (Harter et al., 2011; Minkler, 2012), here I specifically consider some key challenges in critical health communication research that engages efforts at transformative organizing. This essay describes how methodological choices involved with my critical commitments to understanding the political and economic roots of health lead to some unique challenges in the field, and considers how those challenges intersect with the academic politics of training, publishing, and visibility.

HEALTH COMMUNICATION AND TRANSFORMATIVE SOCIAL CHANGE

At one level, I can explain quite rationally how I became involved in these projects. My research is fundamentally concerned with the social construction of health and the politics of illness attributions. Following critical traditions in health scholarship (Waitzkin, 1983; McKnight, 1988; Lupton, 1994; Kirkwood and Brown, 1995), I have critiqued western lifestyle discourses that attribute illness almost exclusively to individual choice-making (thereby overlooking structural factors) and medical discourses that equate achieving good health with access to medical care. Given the critical impulse to promote social change (Waitzkin, 1983; Horkheimer, 1986), I wanted to move beyond ideological critique of problematic discourses to praxis. I therefore sought out efforts, particularly activist organizing, that draw attention to not only the social determinants of health but the *political* roots of health status (Ford and Yep, 2003; Zoller, 2005). Additionally, it seemed to me to be common sense that health communication scholars should systematically address economic inequality, given that the primary predictor of health status is income levels, which are related to gender and racial differences among other issues (Kennedy et al., 1998; Pickett and Wilkinson, 2015). As a result, I investigated the economic dimensions of health including corporate political influence over economy policies, globalization, and occupational and environmental health issues (Zoller, 2012). Having argued for more attention to efforts at transformative change vs. resistance within existing relations of power (Ganesh et al., 2005), I became interested in alternative efforts to organize a more equitable, democratic, and environmentally sustainable economy, including the movement to create a network of Mondragon-style worker-owned, union cooperatives (www.1worker1vote) and an international farm labor certification initiative that partners with retailers, growers, environmental groups, and farm labor unions.

However, this rational account of my research trajectory does not address experiences of doubt and emotion management that arises with critical health communication research in the field that I reference in the opening paragraphs. I have struggled with how to frame parts of my research agenda in ways that engage with the health communication discipline, and grappled with risks associated with studying transformative efforts. Although authors frequently construct confessional tales to share advice and the successful management of challenges in ways that build researcher ethos (Van Maanen, 1988), here I try to put ego aside to discuss lessons learned as well as challenges that I continue to face.

OBSERVATIONS ON THE POLITICAL AND PERSONAL IN CRITICAL HEALTH COMMUNICATION RESEARCH

Here, I describe six observations from my experiences researching transformative social change. I consider issues that may be primarily personal as well as those that we should address as a field.

Our Choices About What to Study Are Linked to the Politics of Academic Visibility

Economic inequalities are at the root of health disparities (Kennedy et al., 1998; Pickett and Wilkinson, 2009). However, researching activism that seeks to transform the economy may not look like the majority of health communication scholarship, which tends to emphasize health education and promotion campaigns, medical interactions, and social support for people with illnesses (see for overview Thompson et al., 2011). Despite growing attention to economic policies in critical health communication research (Zoller, 2004, 2016; DeSouza et al., 2008; Dillon and Basu, 2013), I still find it challenging to address many forms of economic activism as health communication research.

I am studying Apple Street Market because of the transformative potential of the union cooperative movement, affiliated with the labor movement that I mentioned above. The union cooperative movement is an alternative to the corporate economy. The movement's goal of building an equitable and sustainable economy for all, particularly for groups previously marginalized, places its work at the center of reducing health disparities by improving income, working conditions, and building long-term community-based wealth (Dean, 2013). However, I was concerned that researching the Cincinnati Union Cooperative Institute (CUCI) (a major part of that network and the incubator of Apple Street other cooperatives in our region) would not be perceived as health communication scholarship given its emphasis on building a variety of businesses (from manufacturing to cleaning to environmental retrofitting, to groceries). In other words, I did not think that the promotion of economic change alone would appeal to health communication journals.

In this case, I managed this challenge by selecting individual CUCI cooperative initiatives including a farming and food hub operation (Our Harvest) and a grocery store (Apple Street Market) that connected to health via food, vs. the cleaning or energy retrofitting organizations. The food connection seemed more likely to be recognized as health communication research. In this case, the choice was a relatively easy one to make, but other efforts to promote economic change may prove more difficult to adapt. This question of theoretical scaffolding (that is, connecting these topics to health communication) has influenced my research trajectories in the past. For example, I found that I did not do enough theoretical work to make important connections before engaging in research about Cincinnati's 2001 globalization protests, and as a result, I did not publish any of that research in health communication journals. I also found it too challenging to frame efforts such as the Occupy movement overall as health activism even though changes in income inequality would have major health effects.

Building lines of research that connect health and marginalization across contexts would help to pave the way for newer health communication scholars to justify their choice to investigate efforts to address economic and other forms of inequality and social problems to doctoral and tenure committees. It is important to note that I reside in a department that is supportive of critical research and allows department members to build a rationale for our research focus. Other departments may have expectations that scholars align with dominant lines of extant research. As critical health communication researchers, we can do more to create a body of research that connects income inequality and health, including more investigation of health policy as both fundamentally communicative and economic in nature (and vice-versa) (see for example Conrad and McIntush, 2003). Forums like this one are an exciting sign of growing interest in the discursive construction (and deconstruction) of the political structures constituting and mediating health experiences. I look forward to more work that connects the construction of economic relationships as a central component of the discipline, along with research that connects economic discourses with multiple points of marginalization including race, nationality, gender, sexuality (Gillespie, 2001; Dutta and Basu, 2007; Sastry and Dutta, 2011).

Establishing Research Relationships Can be Particularly Challenging With Transformative Efforts

Critical researchers interested in democratic and grassroots efforts at transformative change may find it particularly challenging to reach out and establish research relationships due to the time and resource barriers that these groups face as well as their unique vulnerabilities. These challenges mean that researchers may have to plan for a lot more time prior to research commencing, during what Gonzalez (2000) referred to as the spring or preparatory phrase in her "4 Seasons" approach to ethnography.

I was fortunate that my Apple Street Market and farm labor certification studies garnered research support from a Waterhouse Family Institute grant, and I was particularly grateful that the granting agency was flexible with the timeline because of their experience funding social justice work. It took immense effort to establish research relationships with both entities. CUCI (Cincinnati's union cooperative incubator that I mentioned earlier), is an exciting and energetic organization, but it is comprised of a small group of people who are stretched thin in terms of time and resources. Research dollars were not enough incentive to create time to meet with organizational leaders to build trust, provide information about my research, and to conduct interviews when those leaders were busy attaining funding and growing multiple small businesses. As I discuss in the next section, it was not until I found a way to contribute to the grocery project on my own that I gained access. Although I should not have needed the reminder, it took me quite a while to remember that access is about showing up and making small contributions vs. assuming that our research goals themselves will be immediately valuable to the organizations we study.

The farm labor multistakeholder certification initiative that I mentioned earlier is a nascent transnational organization with the backing of major retailers, unions, and NGOs. It was very challenging to establish relationships with the founders of this initiative because leaders were concerned about potential negative coverage that could jeopardize their efforts, which relies on positive reputation in the form of product labeling. After much negotiation, access entailed signing a research agreement that limits what my co-researchers and I can publish about the organization. The agreement is a clear ethical conundrum for a critical scholar. Obviously, each case of negotiating access has to be considered on its own merits. In this instance, after discussion with my research partners who were more familiar with this approach, I decided that access to this unique initiative and the opportunity to highlight efforts to improve working conditions, safety, and pay for marginalized farm workers along with environmental stewardship in the U.S. and Mexico was worth the limitation.

I have to admit that the time spent negotiating access and then delays in these projects have slowed my publication rate recently. Scholars have to weigh these risks to their research trajectory against their career needs. For example, I have engaged in these projects after achieving promotion to "full." I also have spent some time doing theoretical work and textual analysis between participatory projects. At the same time, personal characteristics come into play here as well because I was simply too stubborn to move on to different research contexts after I determined that I wanted to study these organizations. It would be wise for scholars in more precarious positions to cast a wider net of potential research settings and participants, when possible.

Transformative Change Efforts May Challenge What You Consider to be a Research Contribution

When you do establish a participatory relationship, the efforts may well be in need of support in exchange for access that does not directly relate to our research expertise or educational training. I ultimately gained access to Apple Street Market because I showed up for volunteer meetings and just happened to know a good bit about bingo (of all things) when they were conducting a fundraiser. Setting up for bingo led to discussion of my expertise in cooperative organizing, but I was primarily invited onto the board by the Project Manager to assist with marketing and social media management. Serving on the board was a way for me to contribute to the organization, a fundamental component of critical, engaged research (Minkler, 2012). However, these areas where they were looking for help are not primary areas of research or professional expertise for me (I have some level of knowledge based on research and teaching). Moreover, as I described at the start, serving on the board also entailed learning about the complexities of financing and building a community/ worker-owned cooperative grocery store, which includes issues like securities law and building codes. I have experienced a steep learning curve in these areas.

Although it is far from glamorous, acting as the Secretary for the board as a part of my participant-observation research, will *eventually* translate into a role as an organizational historian in order to preserve insights about efforts during its founding, share insights with other CUCI cooperatives and the larger cooperative movement through multiple popular education outlets that they promote (including conferences, low-cost handbooks, websites, etc.), and build communication theorizing. I would also note that involving students in a graduate qualitative methods course doing focus groups and market research was a way to build mutual research benefits for the market and to my department.

On the other hand, the food labor certification initiative leaders found my *research* background in organizational participation to be potentially valuable. In that case, though, my ability to conduct focus groups in the U.S. and Mexico was severely limited by poor quality conversational Spanish and a lack of in-depth knowledge about daily farm operations. This study serves as a reminder that negotiating access with vulnerable populations may require working in partnerships. The organization put me in partnership with scholars who are fluent in Spanish and experts in farming practices, and my grant provided resources to translate interviews (Perhaps there is a lesson here about the *benefits* of stubbornness, as these obvious shortcomings probably should have deterred me from pursuing the project).

Overall, we should consider that the needs of community-based and social movement organizations are likely to be different than research that takes place in major health care institutions such as hospitals or workplaces. These organizations may be able to dedicate time and resources to projects and may be able to more easily incorporate contributions that emerge from our research specialties. For example, my trajectory was likely quite different from Eisenberg et al. (2006) (incredibly insightful) applied research with a hospital. Although I am sure this project was also very challenging, hospital leaders had time to learn about the value of building a narrative to address patient experience, and the resources to encourage research participation from employees. Therefore, scholars who engage with grassroots and other marginalized groups engaged in transformative social change should be prepared to contribute in a multitude of ways to the effort, remaining flexible and open to continual learning in an unpredictable environment.

Researching Efforts at Transformative Change Can be Risky to Academic Publishing Expectations

In addition to delays in accessing research sites, there are other risks to academic timelines. Efforts to promote democratic, transformative change are often organized from the margins, by those with less investment in dominant systems. Proponents of transformative change, particularly grassroots groups, cannot generally rely on acquiring existing resources, and face an often skeptical public that may view the efforts as fringe (Parker et al., 2014). The politics of "feasibility" occupies public imagination in terms of beliefs about what is possible and realistic (Therborn, 1980). As a result of these challenges, transformative efforts are often SLOW and precarious, risking collapse at any time. At the same time, these organizations often have significant needs for volunteers and can take as much time from you as you can give. These factors mean that researching transformative efforts may entail a significant investment of time in initiatives that may not come to fruition. Scholars at different stages of their career have to take this risk into consideration when choosing projects.

In the case of Apple Street Market, I am interested in how store employee-owners participate in decision-making and the influence that voice has on their quality of work, stress, and occupational health, as well as what role the store can play in reducing community health disparities. However, the community has been organizing for 5 years and the market is still not open. Opening a grocery is a very expensive and complicated process, and building cooperatives with an appropriate debt ratio involves a lot of fundraising from small donations and major institutions. A small group of volunteers has an enormous workload. And, as I indicated at the start of the essay, the store may never open because of a collapse in funding resulting from delays and changes in tax codes and market conditions.

There is no simple set of directives about how to manage these risks, but I offer a few observations here. First, as my colleague Shaunak Sastry had to remind me, failed efforts are still instructive. We simply have to keep risk that in mind as we pose research questions and make plans for future publications. "Keeping this in mind" also involves managing our own frustrations and emotional reactions when projects do not come to fruition. I have experienced that frustration at delays as well as serious concerns about community members who have given to the project and may end up without a grocery store to show for their efforts.

Critical researchers also should carefully weigh how you spend your time in light of your professional goals. If the project is something you are passionate about and would volunteer for without the research component, that certainly helps. However, not everyone has enough free time to do that given work and other life commitments. In my situation, I am interested in researching many of CUCI's incubated cooperative initiatives, so I feel like the investment of time in one project is worth it to learn more about other initiatives. For example, I also conducted an interview and observation project (vs. participatory project) with the Our Harvest food hub, so that "data" is something that I can count on. Practically, researchers can gather texts and other "durable" artifacts for investigation when researching transient organizing that may not last.

Researching Transformative Change Requires Possibly Unique Forms of Patience and Emotional Labor

Deetz (2005) suggested that critical scholars should be "filled with care." Multiple authors encourage reflexivity before entering the field so that we understand our own strengths and weaknesses as they relate to the research process (Sharf, 2005; Field-Springer, 2019). I have practiced reflexivity and the need to listen open-mindedly to those who express viewpoints very different from my own, for example, in research about environmental health around a chemical plant. Graduate methods courses helped me to consider the politics of representation when researching with marginalized groups in community organizing. No level of reflexivity has prepared me to react well, however, when I find myself or the organization I am working with being criticized for our work by folks who want to experience the benefits of organizing but are not themselves volunteering. I remember having been yelled at by a man who did not want to stay on the sidewalk during a protest about police violence against African Americans (a second phase after the globalization protest). He was upset that we had yielded to this police demand. I did not react with the cool detachment of a researcher. I was angry that he only showed up at the event, vs. at any of the previous planning, ready to criticize those who had put in the time to organize the event. To this day I wish I had yelled, “Should have been at the meeting!” I deal with this frustration again now when community members earnestly offer multiple ideas for how Apple Street Market should raise funds or ask why we are not engaging in any number of fundraising initiatives without volunteering to help with those activities. In this case, I have to smile and thank people for their ideas (and ask if they will donate their time) because losing patience would damage the effort.

I am suggesting that this form of emotional management is somewhat unique to efforts at democratic, transformative change because the development of a politics of solidarity, at least in Western contexts, runs counter to the ingrained ideology of individualism (Brecher et al., 2000). For example, there seems to be a limitless need to educate people about cooperative principles so that they understand that a cooperative is made up of its members, and that there is no “they” who can create and deliver a grocery store to the community. Moreover, as many can attest, despite the ostensibly liberatory goals of progressive organizing such as the globalization movement, encountering sexist ideologies and behaviors (as well as racism, classism, homophobia, and other forms of bigotry that other scholars may experience) remains challenging. These encounters require emotional processing and organizational work while you are trying to support the goals of the overall movement.

As a discipline, we can do more to incorporate readings in our graduate courses that address the emotional work involved in critical health communication (Dutta and de Souza, 2008). Additionally, experiential learning with transformative social organizing would better prepare future critical researchers for these everyday challenges (Artz, 2001).

Facing Material Risks and Dangers

Finally, as I indicated at the start, transformative efforts may entail material risks to researchers. I mentioned that Cincinnati police had my car towed from a protest event and then tear gassed protestors at the globalization demonstration. Colleagues and friends would commonly express concern about the safety of the “parts of town” where we held organizing meetings for those events (I would note that despite our efforts many of those areas have since been gentrified so people are not so concerned now when I am in the same areas, so we must continually interrogate what counts as “dangerous” and the way that overlaps with class, gender, and racial issues).

These risks are relatively minor examples, but critical health communication researchers should carefully weigh their own safety risks. Studying transformative efforts can be threatening to dominant interests. In his blog, Mohan Dutta discussed the fears of government intimidation following his work to raise the voices of immigrant labor in Singapore (http://culture-centered.blogspot.com/2018/11/why-voice-matters-take-look-at.html). Scholars have to carefully consider how to gather data in ways that protect them from material, legal, and symbolic risks. Institutional guidance and support from our departments and universities may be necessary, although as scholars we may have to advocate for such support, particularly for faculty in more contingent positions.

CONCLUSION

As I previewed, some of these points represent ongoing challenges that I will have to continue to manage. These challenges are ones that other critical health communication scholars also may have to negotiate in each research project. These issues include letting go of preconceived ideas about how your expertise may help a given project, while balancing that flexibility with managing boundaries regarding your time and contributions. Researching transformative change involves deciding upfront how much risk you are willing to take and planning for what you can learn from a project that may not get off the ground. This research may involve significant negotiation of the balance between open and free inquiry and the vulnerabilities of the organization and the researcher.

Other issues that I have discussed have disciplinary implications. As critical health communication researchers, we can do more to create theoretical pathways for scholars who wish to make linkages among communication, health status, and the economy, as well as multiple forms of structural and social inequalities. Forums like this one are an important avenue for those conversations. Graduate education and mentorship should include more preparation for the unique challenges discussed here. Additionally, critical scholars should work in their home institutions and through organizations like NCA and ICA to promote tenure and other disciplinary standards that account for time-intensive research and acknowledge the value of engaged and participatory scholarship with marginalized groups engaged in social change efforts.

Having outlined significant challenges in critical health communication research, it is important to note that engaged research with transformative efforts is challenging but rewarding work that has the potential to make significant theoretical and practical contributions. I hope that discussion of these issues is helpful, particularly for junior scholars, as we evolve to address contemporary social needs.

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

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BRIEF RESEARCH REPORT
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Constructing the (Healthy) Neoliberal Citizen: Using the Walkthrough Method "Do" Critical Health Communication Research

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Introduction: Since the launch of Web 2.0, we have witnessed a trend toward digitizing healthcare tools for use by both patients and providers. Clinical trials focus on the ways that digital health technologies result in better outcomes for patients, increase access to healthcare and reduce costs. Critical approaches which explore how these technologies result in changes in patient embodiment, power relations, and the patient-provider relationship are badly needed.

Objective: To provide an instructive case example of how Light et al.'s (2018) walkthrough method can be mobilized to study apps to address critical health communication research questions.

Methods: We apply the walkthrough method to the BEACON Rx Platform. In doing so, we conduct a detailed technical walkthrough and evaluate the environment of expected use to answer the following questions: How does the platform shape (and how is it shaped by) understandings of what it means to be healthy? Who are its ideal users? How does this impact its environment of expected use?

Conclusions: This paper demonstrates the potential contributions of the walkthrough method to critical health communication research, namely how it enables a detailed consideration of how an app's technical architecture and environment of expected use are embedded with symbolic representations of what it means to be healthy and what practices should be engaged in to maintain "good" health. It also demonstrated that, despite the rhetoric that digital health technologies democratize healthcare, the BEACON Rx platform is a risk monitoring tool by its very design.

Keywords: mental health, apps, surveillance, neoliberalism, walkthrough method, critical health communication

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INTRODUCTION

"It's like having a physician in your pocket" (Lupton and Jutel, 2015, p. 130). This quote reflects current trends toward digitizing healthcare tools for use by both patients and healthcare providers. This shift toward digital solutions is especially prominent in mental healthcare, with ∼29% of all health smartphone applications ("apps") being used for the diagnosis, treatment, or support of psychiatric disorders (Anthes, 2016). Currently, there are ∼965 and 470 apps targeting mental health disorders in the Google Play and iTunes stores, respectively (Larsen et al., 2019). This includes apps such as Headspace, a guided-mediation app that targets stress, anxiety and sleep; Moodpath: Depression and Anxiety, in which users can monitor their own depression symptoms through daily assessments and access personalized guidance and resources based on their results; and, Youpper, an "emotional health assistant" which uses artificial intelligence to "[interact] with you, [learn] from you, and [become] attuned to your needs over time" (Youpper, 2019).

In addition to commercially available apps, clinicians are now receiving funding to develop their own apps for incorporation into routine clinical care to better monitor their patients' treatment outcomes. For instance, the CanImmunize app was developed by a physician to create a digital version of individual and family immunization records, including: information about vaccinations and related diseases; customized vaccination schedules for each family member; reminders for upcoming vaccination appointments; and, information about regional disease outbreaks (Houle et al., 2017). The BEACON Rx platform, which is the focus of this case study, was similarly developed through a partnership between the Ottawa Hospital Research Institute (OHRI) and private industry to facilitate psychiatric treatment among men who present to the Emergency Department for an episode of self-harm. Digital solutions such as CanImmunize and the BEACON Rx platform are packaged as a means of putting patients in charge of their own healthcare and disease prevention; however, scholars have expressed a need to examine these technologies critically, with a view of developing an understanding of how they are embedded within a larger discourse of health surveillance in which patients are disciplined into self-tracking and self-regulating subjects. As explained by Ayo (2012), the intent is not to classify digital tools as either "good" or "bad" but, instead, "to demonstrate how such self-regulating, individualized practices become championed over other forms of well-established knowledge such as the social determinants of health" (p. 102).

In order to take up this call for critical scholarship, this paper seeks to provide an instructive example of how to mobilize Light et al.'s (2018) walkthrough method to answer critical health communication research questions specific to health apps. To demonstrate this, we will apply this method to an analysis of the BEACON Rx Platform to assess the following questions: How does the BEACON Rx platform shape (and how is it shaped by) understandings of what it means to be healthy? Who are its ideal users? How does this impact its environment of expected use? In answering these questions, we will advance the argument, using the BEACON Rx platform as a case example, that, despite the neoliberal rhetoric that mental health apps encourage users to take control of their own care, they are, in fact, risk monitoring tools *by their very design.*

LITERATURE REVIEW

The Use of Digital Health Technologies in Psychiatric Care

In this paper, the term "digital health technologies" will be used to refer to internet-based tools which facilitate the delivery of healthcare, also termed "eHealth," "Medicine 2.0" and "Health 2.0" (Lupton, 2013b). This can refer to a broad range of products and services including, but not limited to electronic medical information systems; telemedicine tools which facilitate medical evaluation and diagnosis at a distance; computerized therapies which are designed to deliver health interventions; and, mobile, wireless or wearable technologies which allow patients to monitor their health and well-being (Lupton, 2013b). This paper will specifically focus on the combination of technology and psychotherapy in the treatment of psychiatric disorders such as depression and anxiety. This has also been termed "blended care" in the public health literature and is similar to Lupton's (2013b) definition of telemedicine as the use of "digital and other technologies to encourage patients to self-monitor their medical conditions at home, thus reducing visits to or from healthcare providers, and to communicate with healthcare providers via these technologies rather than face to face" (p. 259). Here, however, digital health technologies are not intended to replace face-to-face contact with healthcare providers, but instead, refer to "any possible combination of regular face-to-face treatments and web-based interventions" (Krieger et al., 2014, p. 285).

To date, few studies have examined the use of digital health technologies in conjunction with routine psychiatric care, but those that have demonstrate promising results (Wright et al., 2005; Carroll et al., 2008; Kooistra et al., 2014; Krieger et al., 2014; Kleiboer et al., 2016). These trials highlight the numerous benefits to both patients and healthcare provides including increasing the intensity of mental health treatment without a reduction in the number of sessions (Kooistra et al., 2014); case management benefits for mental health professionals (Wright et al., 2005); and, the potential to reduce in the number of face-to-face therapy sessions required by patients, in turn, decreasing the total cost of mental health treatments to the health care system (Kleiboer et al., 2016).

While few rigorous clinical trials have been conducted examining the use of blended therapy in mental health care, even fewer studies specifically examine the role of apps in psychiatric care (Watts et al., 2013). However, it has been argued that these devices can significantly enhance therapeutic outcomes by increasing exposure to treatments as well as reducing the demands on clinician time (Boschen and Casey, 2008). Additionally, the use of smartphone apps for the self-management and monitoring of mental health has been found to be generally favorable by both research participants (Reid et al., 2011) and providers (Kuhn et al., 2015; Miller et al., 2019a,b).

While research in the fields of medicine, public health and epidemiology focus on how these technologies result in better outcomes for patients, increase access to healthcare and reduce costs to the healthcare system, there is a need to approach these technologies critically, with a focus on how they contribute to changes in patient embodiment, power relations and the patient-provider relationship (Lupton, 2013b). In response, Lupton (2013b) advocates for an approach that she terms "critical digital health studies," which focuses on the social, cultural, economic and ethical components of digital health technologies. This approach is interdisciplinary in nature, involving theorists from the fields of sociology, anthropology, science, and technology studies (STS), media studies and cultural studies. These scholars focus not only on the instrumental uses of digital health technologies but explore their development within established ideological and discursive contexts (Andreassen et al., 2006; Beer and Burrows, 2010; Greenhalgh et al., 2013; Ritzer, 2014).

"Healthism" and the Neoliberal Rationality

The language of neoliberalism is often invoked in critical analyses of digital health technologies, highlighting how it shapes how health is defined and what practices are promoted to ensure the maintenance of "good" health (Crawford, 2006; Zoller and Dutta, 2011; Ayo, 2012; Lupton, 2014b,c, 2015, 2016; Millington, 2014; Ajana, 2017; Fotopoulou and O'Riordan, 2017; Elias and Gill, 2018). Ayo (2012) describes neoliberalism as "a political and economic approach which favors the expansion and intensification of markets, while at the same time minimizing government intervention" (p. 101). This framework is characterized by minimal government intervention, market fundamentalism, risk management, individual responsibility, and, as a result, inevitable inequality (Ericson et al., 2000). These principles are highly value laden, extending far beyond the economic or the political. Neoliberalism can, thus, be understood as shaping how citizens are "governed and expected to conduct [themselves], right from the privacy of one's own home to the administration of public institutions across all demographics" (Ayo, 2012, p. 101).

This discourse has significant consequences on health and healthcare policy and has led to an "ideology of healthism," first coined by Crawford (1980), which positions the achievement and maintenance of "good" health as the central component of identity, "so that an individual's everyday activities and thoughts are continually directed toward this goal" (Lupton, 2013a, p. 397). Rather than improving social conditions related to health, such as access to basic income, food, clean water and shelter, the state has reverted to frameworks of health that emphasize the importance of individual lifestyle choices (Ayo, 2012). This is necessarily a privileged position in that our ability to achieve healthfulness is necessarily conditioned by factors such gender, race, and class (Lupton, 2013a). Under the discourse of healthism, individuals "choose" to take proactive steps to ensure their own health. This moralistic position leads to understandings of poor health as a failure of personal accountability, rather than one of the state (Ayo, 2012). Here, healthy citizens are equated with "good" citizens. This, in turn, legitimizes discriminatory and exclusionary health policies and practices (French and Smith, 2013). This, consequentially, permeates how we understand what it means to be healthy (e.g., Depper and Howe, 2017).

Modes of Self-Tracking and the "Digitally Engaged Patient"

Digital health technologies are an important part of this trend toward taking personal responsibility for our health as they facilitate the self-tracking of health and related conditions that are necessary in order for individuals to make health-related choices. Lupton (2016) describes self-tracking as "practices in which people knowingly and purposively collect information about themselves, which they then review and consider applying to the conduct of their lives" (p. 2). Digital health technologies, therefore, encourage self-surveillance through what has been termed dataveillance, or surveillance via the collection of mass amounts of personal information to be stored, sorted and analyzed electronically. Invoking the language of surveillance often implicitly signals coercion and, thus, negative consequences. However, here, Lupton's (2014c, 2016) typology of the modes of self-tracking is instructive in that it highlights that various modes and technologies of self-tracking will necessarily vary in their repressive effects. While these modes are not mutually exclusive, it is a useful framework for understanding how self-tracking can, in some instances, be voluntary or even pleasurable. First, she explains, that *private self-trackin*g refers to engagement in tracking practices that is purely voluntary, self-initiated and pleasurable; second, *pushed self-tracking*, refers to that which is initiated or suggested by a third party who "nudges" the user toward behavior change; third, *communal self-tracking*, refers to groups or communities of trackers who share their data via social media or other avenues for the purposes of engaging with and learning from one another; fourth, *imposed self-tracking*, occurs when self-tracking is initiated by institutions (e.g., one's employer or school) where individuals have little choice in whether or not to engage in self-tracking practices due to either limited opportunities for refusal or the consequences of non-tracking; and, finally, *exploited self-tracking*, refers to the repurposing of self-tracking data by commercial entities (e.g., market research firms) for the financial benefit of others (Lupton, 2014c, 2016). Lupton's (2014c, 2016) typology highlights how surveillance, as articulated through self-tracking practices, is not necessarily repressive, but instead, speaks to Foucault's concept of governmentality in which social control "[operates] on autonomous individuals willfully regulating themselves in the best interest of the state" (Ayo, 2012, p. 100). His concept of the panopticon, likewise demonstrates how control and discipline work together to ensure the production of "good" citizens (Foucault, 1977). Self-tracking further illustrates how the creation and monitoring of identity via categorization has also figured prominently into contemporary surveillance practices. Ericson and Haggerty (2006) claim that there are two important dimensions of identity politics in relation to surveillance practices: (1) the monitoring of pre-constituted social groups; and, (2) the creation of new forms of identity through risk categorization. Borrowing from Guattari and Deleuze (2000) and Haggerty and Ericson (2000) describe a nearly invisible model of surveillance in which individuals are de-territorialized and separated into discrete flows of information. These flows, referred to as "data doubles," are highly mobile, reproducible, transmittable, and continually updated. Barnard-Willis (2012) describes these electronic profiles as taking on a life of their own as they are often seen as *more* real, accurate and accessible than the individual themselves. Within this understanding, he explains that "identity is shifted from the individual to their representation in multiple databases" (p. 33).

This is similar to Foucault's (1977) concept of biopower, or the subjugation of bodies and the control of populations (p. 140), which instructs citizens on the "right" ways to live and govern oneself. Here, understandings of "risk" and "normality" are essential, especially in relation to health. Digital health technologies, thus, allow for new refinements of categorization, enabling increased specificity in the identification of "risk factors" and "at-risk groups" in need of medical targeting (Lupton, 2012). Normative expectations are inherent to risk calculations in the sense that their categorizations are infused with an amount of moral certainty and legitimacy (Ericson and Haggerty, 1997). This presents the achievement of "good health" as an ongoing, forever unfinished project in which even healthy individuals are potentially "at risk" and must, therefore, engage in proactive self-monitoring practices in order to remain in good health (Lupton, 1995).

These practices, therefore, produce a very specific kind of subject: an entrepreneurial citizen who uses digital health technologies to engage in self-surveillance in order the ensure the most accurate representation of their health which they can then act upon as necessary (French and Smith, 2013; Doshi, 2018). The work of Foucault has been especially relevant in mobilizing critical examinations of digital health technologies and subjectivity (French and Smith, 2013; Williamson, 2015; Esmonde and Jette, 2018). Engagement in self-tracking practices via digital health technologies has been theorized as giving rise to a "quantified self" (Lupton, 2014c; Nafus and Sherman, 2014), or a self that uses apps to "to collect, monitor, record and share a range of – quantified and non-quantifiable—information about herself or himself while engaging in 'the process of making sense of this information as part of the ethical project of selfhood"' (para. 9). The engagement in self-tracking practices under the guise of health has been likened to technologies of the self, in which individuals take actions to "transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality" (Foucault, 1977, p. 18) Technologies of the self, in this case digital health technologies, then, interpellate particular subjects or identities (Ayo, 2012; Depper and Howe, 2017; Esmonde and Jette, 2018). Lupton (2013b) uses the term "digitally engaged patient" to describe the subject that emerges through interactions with digital health technologies, highlighting that, through discourses which emphasize patient empowerment and the availability of digital health monitoring tools, the patient is constructed as one that is "at the center of action-taking in relation to health and healthcare" (Swan, 2012; as cited in Lupton, 2013b, p. 258). Lupton (2012) explains that the digitally engaged patient is far from disembodied but, instead, is involved in a continuous circuit of data production and response, with information generated by digital health technologies being fed back to the user in a format that encourages the user to act in particular ways (Lupton, 2012).

Objectives

The primary objective of this study is to provide an instructive case example of how the walkthrough method (Light et al., 2018) can be mobilized in the study of apps to address critical health communication research questions. To demonstrate this, we will apply this method to an analysis of the BEACON Rx platform to assess its environment of expected use to address how it shapes (and how is it shaped by) understandings of what it means to be healthy, its construction of ideal or default users, and who is, consequently, rendered invisible through these constructions.

The BEACON Rx Platform and Cluster Randomized Controlled Trial

The BEACON Rx Platform was developed through a partnership between CHESS Health Inc. and the Ottawa Hospital Research Institute (OHRI) and is designed to extend the reach of face-to-face psychotherapy for men who present to the Emergency Department for an episode of self-harm. The digital health solution is one component of a complex clinical intervention that is being evaluated through a cluster randomized trial (CRT) in seven Emergency Departments across the province of Ontario. The BEACON Rx platform includes both a patient-facing app and a health provider-facing dashboard. The app includes eight integrated sections, including: a user profile; a home page, where users can monitor any number of "trackables" (e.g., diet, hygiene and exercise) and mental health outcomes (e.g., mood); materials designed to support face-to-face psychotherapy; a journaling function; a connect feature which allows users to instant message their healthcare provider in between visits; a progress tab where users can review changes to their trackables and mood over time; a resource section which allows their healthcare provider to push out targeted content through the app; and, "the BEACON button" which users can press should they find themselves in a mental health crisis to be connected to their provider, emergency contact or crisis support line (**Figure 1**). The BEACON Rx Clinician Dashboard facilitates provider case management through the monitoring of patient's progress. Through the Clinician Dashboard, the provider can access anything that is inputted into the app by the patient, including responses on mood logs, trackables, journal entries, and BEACON button presses.

Both authors were involved in the development of the BEACON Rx platform, as Principal Investigator [SH] and Clinical Research Coordinator [SM], assisting with the development of the clinical content to be included in the platform and providing commentary and feedback on its technical architecture. Beyond this, both authors were involved in usability testing of both the beta and current version of the BEACON Rx platform. As such, it is possible that our familiarity with the platform impacted our findings in this study.

The Walkthrough Method

Despite the proliferation of apps that accompanied the emergence of Web 2.0 innovations, their empirical study brings with it significant methodological challenges. For instance, unlike webpages, they are technically closed systems and researchers rarely have access to their proprietary source code, rendering examinations of their operating structure difficult, if not impossible (Light et al., 2018). While researchers have attempted solve this problem via queries of Application Programming Interfaces (APIs) (e.g., Bivens, 2017), the data gathered are often incomplete, limited to variables which are relevant for commercial or advertising purposes.

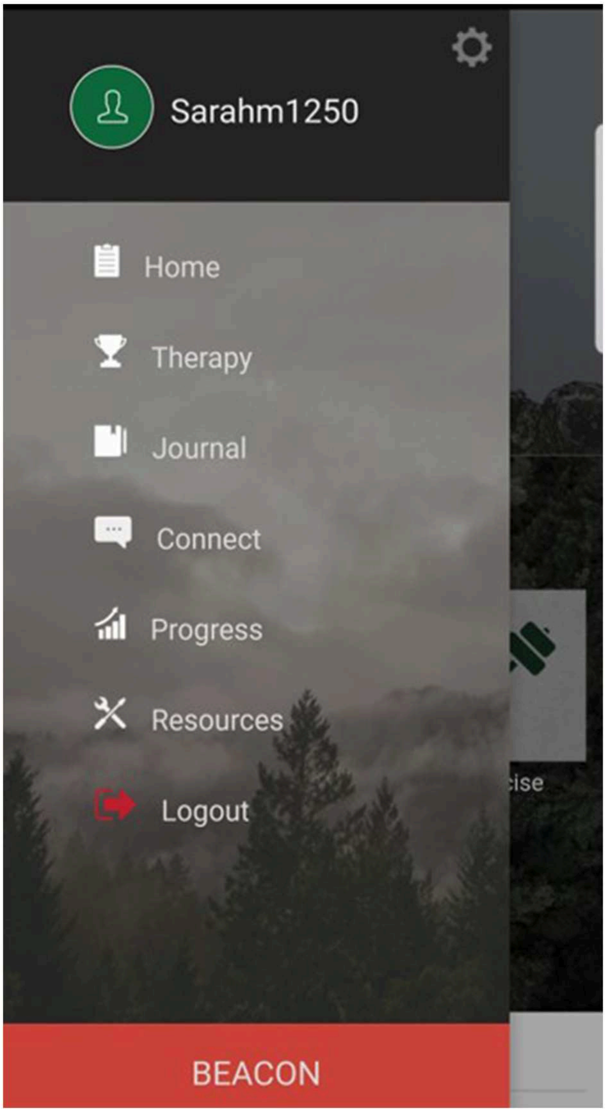


FIGURE 1 | BEACON Rx app menu screen.

To address these challenges, Light et al. (2018) developed the walkthrough method, which combines science and technology studies (STS) and cultural studies to allow for a systematic step-by-step exploration of apps through their various screens, features, and flow of activities: "slowing down the mundane actions and interactions that form part of normal app use in order to make them salient and therefore available for critical analysis" (Light et al., 2018, p. 882). Through this approach, connections are elucidated between an app's technical interface and discursive and symbolic representations (Light et al., 2018). This, in turn, provides an understanding of the environment of expected use; that is, how designers anticipate the technological artifact will be received by users, how it will generate profit and regulate user activities within the app (Light et al., 2018). This approach is ontologically grounded in Actor-Network Theory (ANT) and understands technology as "never merely technical or social" (Wajcman, 2010, p. 149) but, instead, sociocultural and technological processes are understood to be mutually shaping (Light et al., 2018). As explained by Baym (2010), the consequences of technologies are the result of both their affordances and the ways that these affordances are then appropriated by users. To account for this, we need to consider how social conditions give rise to technological artifacts; how these technologies, in turn, promote or constrict behavior; and, how this is taken up, reworked or resisted through everyday use (Baym, 2010). The walkthrough method also draws on aspects from both textual and semiotic analysis in that it involves an analysis of how apps, through their embedded symbolic and representational features, construct our understanding of gender, ethnicity, race, sexuality, and class. However, as explained by Light et al. (2018), the walkthrough method extends these analyses to provide an understanding of how an app "seeks to configure relations among actors, such as how it guides users to interact (or not) and how these actors construct or transfer meaning" (p. 891).

The application of the walkthrough method involves two key components. First, researchers must conduct a technical walkthrough of the app in which they navigate through the app's various screens, menus and functions, generating detailed fieldnotes or recordings (e.g., screenshots). Elements to be explored during the technical walkthrough include: registration and entry, everyday use, and app suspension, closure and leaving (Light et al., 2018). In addition to documenting an app's technological architecture, researchers should also take note of any mediating characteristics throughout the app, including the user interface; its functions and features; its textual content and tone; and, its symbolic representations conveyed through branding, color, and font choices (Light et al., 2018). Second, researchers must establish an app's environment of expected use, which considers the social, political, cultural, and economic context in which it was developed and gives researchers an understanding of who its intended users are and how they are expected to integrate the app into their everyday practices. This involves an assessment of an app's vision (e.g., its purpose, default users, and conditions of expected use); its operating model (e.g., its business model and its mechanisms for generating profit); and, its governance structure (e.g., how an app regulates user activity in service of its vision and operating model) (Light et al., 2018).

The walkthrough method has been applied by a limited number of scholars in the fields of communication, media, and cultural studies. Bivens and Haimson (2016), for instance, used the walkthrough method to explore how gender is represented in the 10 most popular English-language social media platforms, including Facebook, Twitter, and Instagram. Similarly, Duguay (2017) deployed this method to explore how the concept of authenticity is mobilized on Tinder, a popular mobile dating app. We seek to add to this literature by applying the walkthrough method to the BEACON Rx platform. To our knowledge, at the time of writing, this is the first study to apply this methodology to health apps.

Data Collection

In applying the walkthrough method to an analysis of the BEACON Rx platform, we created a patient-user profile, an administrator-user profile, and a provider-user profile to tour the platform environment. We then took photos of all screens presented to each type of user, which are included in **Supplementary Material** to this paper. All app screenshots were generated using Samsung S8 with Android version 9 and all clinician dashboard screenshots were generated using version 75.0.3770.142 of Google Chrome. This screenshot data is supplemented by analysis of study materials made available through the BEACON Study cluster randomized trial, including the informed consent form and study training manual.

FINDINGS

The Technical Walkthrough

Registration and Entry

We began our technical walkthrough by downloading the BEACON Rx app from the Google Play Store. While anyone can download the app in the Google Play Store, only those with a valid agency identification number ("Agency ID") can create an account. Once a user creates an account, this account must then be validated by an administrator-user through the Clinician Dashboard. Only once this has been done, can the patient-user successfully log in to the BEACON Rx app. Clinician Dashboard registration and entry for administrator- and provider-users occurs in much the same way, with potential users logging on to the clinician dashboard website (https://dashboard.beacon.ohriprojects.ca/) and selecting "Create Account." In order to sign-up for an account, these users must also input a valid Agency ID number and have their accounts validated by another Clinician Dashboard administrator-user. It is also important to note that developers created a central administrator account to allow for the onboarding of additional administrator-users.

Everyday Use

Patient-users

Once a patient-user has created an account and successfully logged in to the BEACON Rx app, they can navigate to their profile by accessing the app's side menu (**Figure 1**). Here, they are encouraged to upload a profile image and/or cover image by either taking a photo of themselves or accessing their photo library to select a photo; update their name as per their preference (e.g., patient-users can use pseudonyms if they do not want to use their real names); and, add a mantra for themselves. In this section of the BEACON Rx app, patient-users can also create or edit an existing safety plan, which is "a procedure that is collaboratively developed to support the participant [to] problem-solve [in] moments when they feel they may be at risk of harm to themselves" (Dunn, 2018, p. 22). The safety plan includes the following elements: warning signs, which are "negative thoughts, moods, and behaviors, that you develop or experience during a crisis"; coping strategies, or "things you can do for yourself to take your mind off a crisis"; high risk locations which "are places or unhealthy social settings you want to avoid to stay on track with recovery"; safe locations, or "places where you can go where you feel safe"; support contacts, described as "people who are good to be around"; and, environment actions, or "things you can do to limit access to ways of hurting yourself and keeping your environment safe" (BEACON Rx, 2019). While users are encouraged to create a safety plan with their health provider during their first therapy sessions, the app does not prevent them from editing these fields outside of therapy. Patient-users can also access the app's setting through its side menu, where they can access push notification settings (e.g., "Alerts"); options to clear their history, although, at the time of writing, users were not able to clear their app history, and "BEACON" settings, where they can update their emergency contact person.

Once a patient-user logs in to the BEACON Rx app, they are immediately taken to the app's home screen, but the home screen can also be accessed from the side menu (**Figure 2**). Here, patient-users are encouraged to update their mood. Once they select "Update Mood," the patient-user is prompted to rate their mood on a five-point scale, from "very low" to "very good." As they toggle this button, the animated figure of a man changes color from deep red (indicating very low mood) to bright green (indicating very good mood) (**Figure 2**). Following this, as the patient-user scrolls through the home screen, they are also encouraged to log any number of the following trackables, each with its own icon: hygiene, sleep, exercise, meals, water, caffeine intake, alcohol consumption, use of tobacco products or drug use. Provider- and administrator-users also have the option to create a "custom trackable" to capture any other variable interest. Finally, at the bottom of the home screen, the patient-user can find a list of their day's reminders, which they can set in other parts of the app to remind them to attend appointments, take medication or complete goals they have set during face-to-face therapy with their healthcare provider.

Patient-users can then navigate to the side menu to access the "Therapy" section of the BEACON Rx app. This section is designed to house clinical tools to be used either in therapy with their healthcare provider or by the patient-user as homework. Here, the patient-user can create goals and access therapy materials, such as therapy worksheets, that have been uploaded by their healthcare provider. In creating new goals, a key part of the psychotherapeutic intervention, the patient-user is taken through seven separate screens: "identify," in which users can identify problems that they are currently experiencing; "select," where users must select a problem they would like to work on; "define" where users are asked to write a problem statement; "generate" in which patient-users can brainstorm potential solutions to the problem they have identified; "choose" where they must choose which solution they would like to implement; "create" which prompts users to develop a SMART action plan (e.g., one that is Specific, Measurable, Achievable, Relevant and Time-bound); and, finally, patient-users must name their goal in order to save it. In this final screen, users also have the option to set alerts to remind them to complete their goals. In this section of BEACON Rx, the app is designed to elicit particular information and behaviors from patient-users; for instance, it is not possible to move forward from the "identify" screen without inputting at least one problem. Similarly, patient-users are not able to save

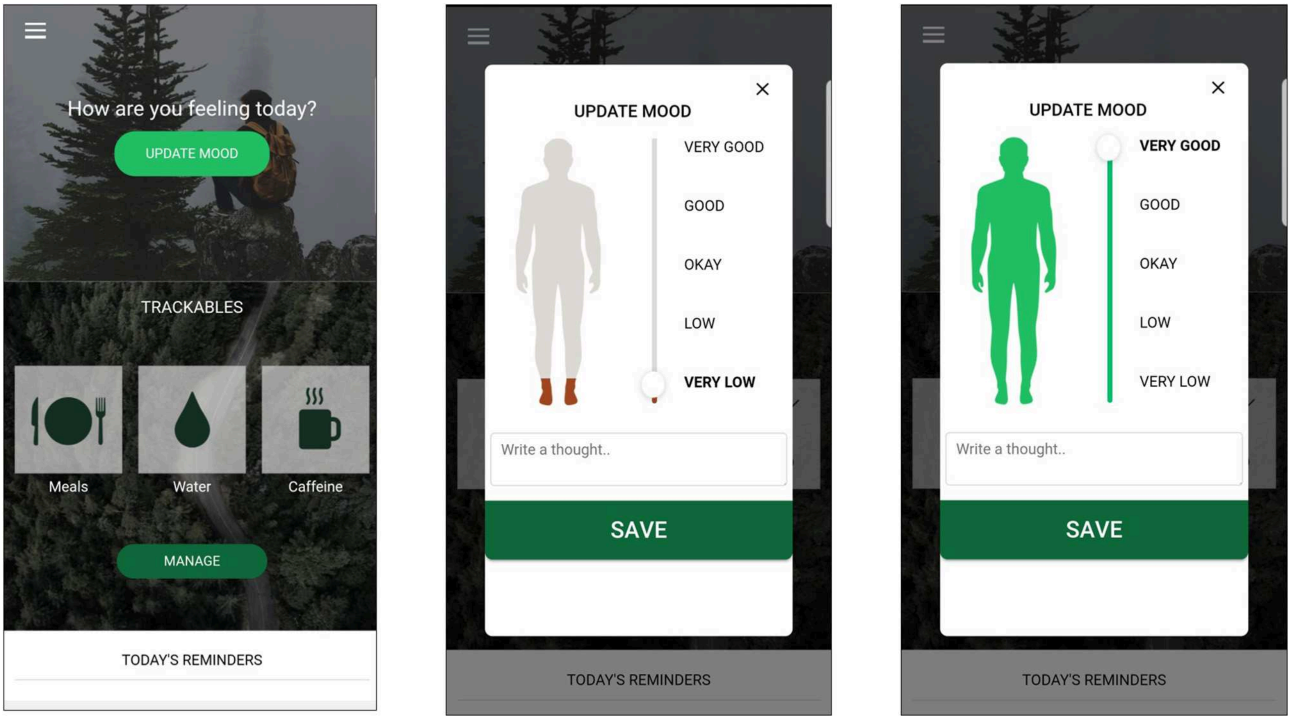


FIGURE 2 | BEACON Rx app update mood screens.

their goal unless they have gone through and inputted all required information in all goal screens (**Figure 3**).

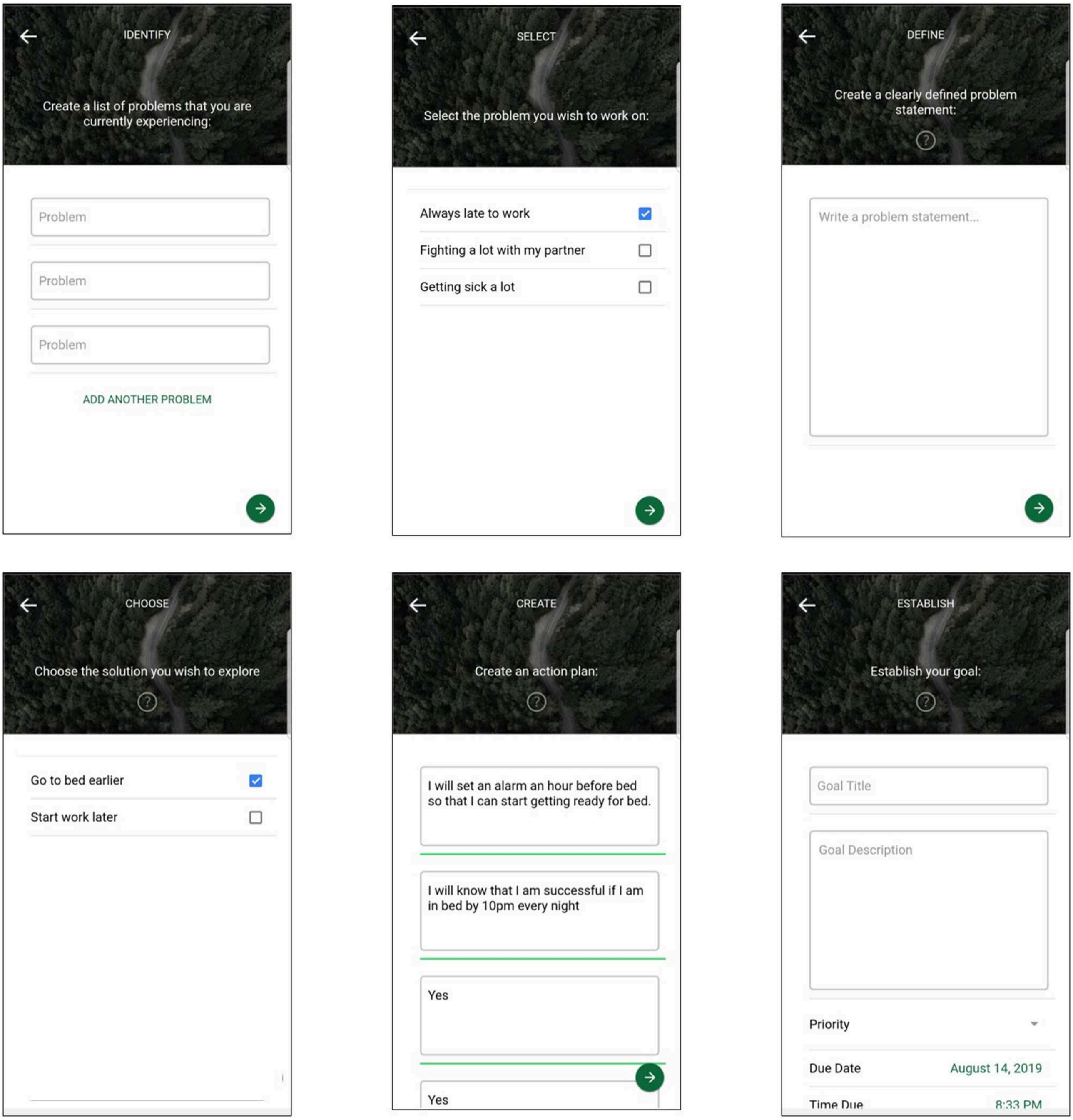
Next, in the "Journal" section, patient-users may select one of 35 writing prompts or write a journal entry on a topic of their choosing. They may also append audio notes recorded via the app or photos from their camera or photo library to their entries. In the "Connect" section of the BEACON Rx app, patient-users may enter a list of their contacts, which will appear in a list in this section, as well as access a chat section. Patient-users can call anyone from their contact list directly from the BEACON Rx app. In the chat section, a patient-user can send a message directly to their healthcare provider in between face-to-face sessions. Messages are read by the provider via the Clinician Dashboard. Through the side menu, patient-users can also access the "Progress" section, where they can track changes to their moods and trackables over the previous week, month, or year. In the "Resources" section of BEACON Rx, the patient-user can access targeted content that has been uploaded by their provider, including links to YouTube videos, audio files and website links. In this section, there is also a tab for local mental health services and crisis lines which have been inputted by their provider and suggested based on a patient-user's location.

Finally, should patient-users find themselves in a mental health crisis, they are encouraged to press the "BEACON Button" which is a large red button located in the app's side menu (**Figure 1**). When the patient-user selects "BEACON" button, they are prompted with a warning measure to ensure that they meant to select this emergency button. If the user selects "yes," they are taken to the "BEACON" screen where they have access to their safety plan, which can provide them with coping skills to de-escalate their crisis. They are also able to select "Assess Situation" to complete a questionnaire about how they are feeling and which warning signs they are exhibiting. The app then provides them with a recommendation that has been inputted by their provider with advice on what to do next. Finally, patient-users can directly call their emergency contact, healthcare provider, or other support contact from this screen, which they have programmed via the settings and connect menus.

Provider-users

When a provider-user first logs into the BEACON Rx Clinician Dashboard, they are taken to their landing page which mirrors the look and style of the BEACON Rx app. On the clinician- and administrator-user landing page is a list of their pinned users (e.g., their assigned patient-users); a list of user "red pins," which are pre-established events that might signal that a patient-user is in distress, such as a decline in mood, clicking of the BEACON button, entering a high-risk location, or any custom red pins created by their provider-user (e.g., a visit to the Emergency Department); a list of upcoming appointments; and, their patient-user activity feed which logs all actions by their assigned patient-users in the BEACON Rx app (**Figure 4**).

From here, provider- users can navigate to the top right corner to their profile where they can update their contact information and upload a picture from their computer. They can also navigate to the preferences menu to toggle the extent to which they receive notifications, both in the Clinician Dashboard and by email. In module settings, provider- and administrator-users can



IDENTIFY

Create a list of problems that you are currently experiencing:

Problem

Problem

Problem

ADD ANOTHER PROBLEM

SELECT

Select the problem you wish to work on:

Always late to work ☑

Fighting a lot with my partner ☐

Getting sick a lot ☐

DEFINE

Create a clearly defined problem statement:

Write a problem statement...

CHOOSE

Choose the solution you wish to explore

Go to bed earlier ☑

Start work later ☐

CREATE

Create an action plan:

I will set an alarm an hour before bed so that I can start getting ready for bed.

I will know that I am successful if I am in bed by 10pm every night

Yes

Yes

ESTABLISH

Establish your goal:

Goal Title

Goal Description

Priority

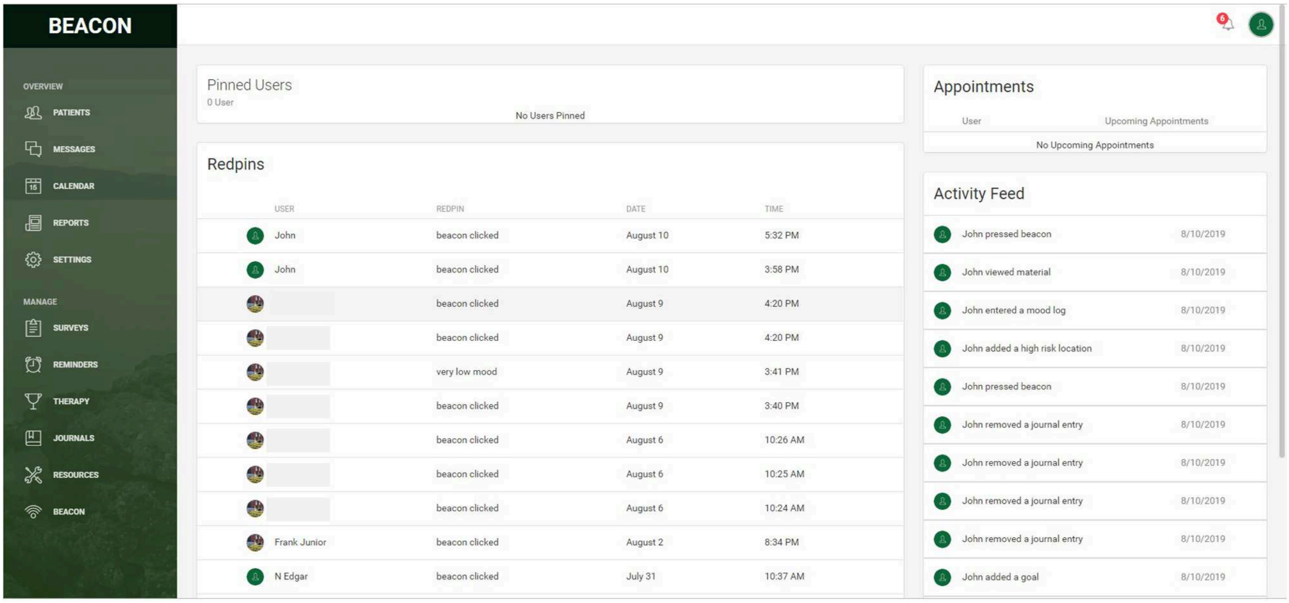
Due Date August 14, 2019

Time Due 8:33 PM

FIGURE 3 | BEACON Rx app update goal setting screens.

edit the look of their landing page by modifying what elements appear here (e.g., patient activity feed, red pins, pinned users, and reminders). Here, they can also edit their pinned users, which appear at the top of their landing page (**Figure 4**).

Next, by clicking on the "Patients" tab, a provider-user can access a list of their assigned patients. Patients whose profile pictures are outlined in blue are "active" patient-users, which refers to patients in the active treatment period of the study intervention, and profile pictures outline in red are "passive" patient users, which refer to patients who are in the follow-up period of the study. From this screen, provider-users can access each of their assigned patient-users' profiles by selecting their profile picture. In the patient profile screen, the provider-user can access any information that is inputted into the BEACON Rx app by their assigned patient-user, including: the details for their safety plan, results on mood logs, reminders, goals created



Pinned Users
0 User
No Users Pinned

Redpins

USER	REDPIN	DATE	TIME
John	beacon clicked	August 10	5:32 PM
John	beacon clicked	August 10	3:58 PM
[redacted]	beacon clicked	August 9	4:20 PM
[redacted]	beacon clicked	August 9	4:20 PM
[redacted]	very low mood	August 9	3:41 PM
[redacted]	beacon clicked	August 9	3:40 PM
[redacted]	beacon clicked	August 6	10:26 AM
[redacted]	beacon clicked	August 6	10:25 AM
[redacted]	beacon clicked	August 6	10:24 AM
Frank Junior	beacon clicked	August 2	8:34 PM
N Edgar	beacon clicked	July 31	10:37 AM

Appointments

User	Upcoming Appointments
No Upcoming Appointments	

Activity Feed

John pressed beacon	8/10/2019
John viewed material	8/10/2019
John entered a mood log	8/10/2019
John added a high risk location	8/10/2019
John pressed beacon	8/10/2019
John removed a journal entry	8/10/2019
John removed a journal entry	8/10/2019
John removed a journal entry	8/10/2019
John removed a journal entry	8/10/2019
John added a goal	8/10/2019

FIGURE 4 | BEACON Rx dashboard patient overview screen.

by the patient-user, journal entries, chat message history between the patient- and provider-user, achievements (however, at the time of writing, these were disabled); information relating to the BEACON button, including any red pins that have been triggered and completed BEACON assessments; and, finally, settings, where provider-users can modify alert settings and patient-users' ability to change these features in the BEACON Rx app. In this screen, provider-users can also edit or add information which will then appear in the patient-users' app; for instance, a provider-user can add an appointment to the patient-user's profile, which will then appear in the reminders section of that patient-user's BEACON Rx app.

Through the "Messages" tab, a provider-user can access the chat history with all of their assigned patient-users. Here, rather than loading each patient-user's profile to respond to potential messages, they are all consolidated in one place. The "Calendar" tab provides a consolidated view of all scheduled patient-user appointments. From this menu, the provider-user can also easily add an upcoming appointment during a face-to-face therapy session which will be reflected in the patient-user's reminders. In the "Reports" section, a provider-user can generate patient-user reports on any number activities of interest, including but not limited to red pins, modifications to the safety plan, and changes in reported mood. However, at the time of writing, this section of the BEACON Rx Clinician Dashboard was not yet enabled. Next, through the "Settings" tab, provider-users may toggle the notifications and email settings associated with the BEACON Rx Clinician Dashboard, including low mood notifications, BEACON Button presses, and high-risk location notifications.

In addition to these day-to-day case management activities, provider-users can also manage the content of the app through the BEACON Rx Clinician Dashboard. In the "Surveys" tab, provider-users are provided with an overview of the mood logs for all of their assigned patient-users, are able to add different trackables to their patient-users' home screens, and, add customized trackables which can be targeted to particular patient-users. Provider-users are also able to send out surveys which have been hard-coded into the BEACON Rx app; however, at the time of writing, this portion of the BEACON Rx platform had not yet been deployed due to technological difficulties. The "Reminders" section allows provider-users to view all assigned patient-user reminders as well as create new reminders for their assigned patients as needed. The "Therapy" section allows provider-users to view all of the goals created by their assigned patient-users and upload relevant therapy materials, such as patient worksheets and psychoeducational materials.

Next, via the "Journals" tab, provider-users can view a consolidated list of all journal entries created by their patients as well as any appended audio-visual materials. The "Resources" tab allows provider- and administrator-users to upload targeted content to the app. It also provides a list of all resource content upload to the BEACON Rx app by all provider- and administrator-users as well as a list of services and crisis lines to be consulted by patient-users. All of the content uploaded in this screen can be either sent to all patient-users or to only a specific few who might find it useful. Finally, the "BEACON" tab allows provider-users to view a consolidated list of all completed BEACON Assessments. It is also here that provider-users may add to a consolidated list of warning signs, feelings, and recommendations which appear in the BEACON Rx app's "Assess Situation" screens.

Administrator-users

Administrator-user accounts are identical to provider-user accounts with two important exceptions: the ability to approve new provider-users, and the ability to approve and assign new patient-users to provider-users. When the "Approve" tab is selected, an administrator-user can view all new patient- and provider-user accounts as well as approve or deny these requests. This screen also provides a list of all current administrator- and provider-user accounts. Through this screen, administrator-users have the ability enable/disable user access, delete provider-users as well as toggle a user's account type (e.g., provider/administrator). Next, via the "Assign" tab, administrator-users can approve new patient-user accounts and assign them to the appropriate provider-user(s). In this section, an administrator may also select a provider user to view/modify their list of assigned patients.

App Suspension, Closure, and Leaving

Administrator-users

While patient- and provider-users can log out of the BEACON Rx platform, they are not currently permitted to delete or close their accounts. While an administrator-user can delete a provider-user account through the "Approve" section of the BEACON Rx Clinician Dashboard, currently, patient-user accounts cannot be deleted; they can only be disabled at the end of their participation in the study (e.g., either at withdrawal or study completion).

Terms of Use

Given that the BEACON Rx Platform is currently designed to support an interventional treatment, no terms of use content exists within the platform. Instead, this information is reviewed with patient-, provider-, and administrator-users prior to use. Prior to enrollment in the study, patient-users are asked to review the study's Informed Consent Form, which includes information related to the BEACON Rx platform as an intervention, how it is to be used, and data privacy and confidentiality information. Prior to onboarding, provider- and administrator-users are trained using the Study Treatment Manual which details how each session of face-to-face therapy is to be conducted and how the BEACON Rx platform is to be incorporated into these sessions.

The BEACON Study's Informed Consent Form explains to patient-users that the app is designed to use "the power and convenience of the internet to allow simultaneous and time delayed communication between an individual and their therapist, as well as the delivery of cognitive behavior therapy and access to resources designed specifically for self-harm" (Hatcher, 2018, p.2). Similarly, it summarizes research revealing that men are less likely to seek mental healthcare services for the treatment of self-harm and are, thus, more likely to die by suicide than their female counterparts. The BEACON Rx platform has therefore been designed to fill this gap in care and encourage men to seek support by making it available to them with the click of a few buttons, on devices that they carry with them everywhere. In explaining the functionality of the app, the Informed Consent Form highlights the importance of the mood log and GPS functionality embedded with in the app which, while optional, are designed to help patient- and provider-users monitor the risk of subsequent self-harm or suicide. Finally, it is explained to patient-users that provider- and administrator-users will have access to all information that is inputted into the app by patient-users and, as a result, they may "discover thoughts or behaviors that raise concern about harm to yourself or others. If the research team sees anything that suggests you or others face imminent risk of harm, they will contact appropriate staff members to intervene" (Hatcher, 2018, p. 5).

Similarly, the Study Treatment Manual, which is used to train all new staff members (e.g., provider- and administrator-users) and introduces the BEACON Rx Clinician Dashboard as a tool to "manage and monitor both progress and setbacks experienced by participants" (Dunn, 2018, p. 12). The manual also encourages study staff to download the BEACON Rx app to become familiar with it in order to build trust and rapport with future patient-users. Provider- and administrator-users are encouraged to set aside at least 30 min each day to "track daily check-ins, receive and send messages, and review participant [app] usage" (p. 14). Prior to detailing the session-by-session breakdown of the therapy being used in the study, the Study Treatment Manual includes a section on safety planning and relapse prevention. This section guides future provider-users through the steps to establish a patient-user's safety plan. This is an essential task that begins at the start of the therapeutic relationship. Central to this plan is the identification of risk and protective factors.

DISCUSSION: THE ENVIRONMENT OF EXPECTED USE

Vision

The BEACON Rx platform's vision is clearly laid out for prospective patient-, provider-, and administrator-users through the terms of use documentation (e.g., Informed Consent and Study Treatment Manual documents). Through the analysis of these documents we see that the BEACON Rx Platform, despite language around patient empowerment, is designed as a risk-monitoring tool for men, identified as a high-risk, treatment-adverse group. The language of risk is mobilized throughout both the BEACON Rx platform and its terms of use documentation. Patient-users are informed that the platform will be used to "monitor their risk of self-harm" and the extent to which they move in and out of "risky" locations. Through the explanation of the safety and suicide risk management protocols embedded within the platform and larger study, it is explained to patient-users that their usage data will also be used to monitor risk, and should the combination of data suggest that they are at risk, the appropriate members of their care team will intervene. Similarly, the technical structure of the BEACON Rx platform is also based around risk, which can be seen through the establishment of the safety plan, the use of red pins to notify the provider-user that their assigned patient-users are engaging in risky behaviors, and notifications received by patient-users when they enter "risky" locations. Within this conceptualization, the healthcare provider now has access to unlimited amounts of information about their patients to facilitate diagnosis and risk categorization. The BEACON Rx platform, thus, separates patients into innumerable categories based on their risk of self-harm. Patients who are perceived as being at greater risk for self-harm, in turn, receive greater follow-up from their providers. This categorization of individuals is essential to the neoliberal rationality in which "at risk" populations are targeted as requiring a greater degree of disciplinary control (Lupton, 2012).

This constructs the ideal BEACON Rx patient-user as once who proactively and dutifully tracks his mental health symptoms and triggers and who, upon review with his healthcare provider, modifies his behavior accordingly. This mirrors Lupton's (2013b) description of the "digitally engaged patient." Patient-users are engaged in a feedback loop in which they not only generate endless amounts of data for their provider through the use of the BEACON Rx app, but they are then expected to modify their behavior accordingly based on the data that have been generated. Not only are patient-users expected to truthfully report their mood and other variables of interest to their provider, they are also expected to proactively consult online and community resources available through the app in between face-to-face sessions with their provider. Further to this, they are also expected to alert their provider when they are in a mental health crisis by pressing the BEACON button, which directly connects them to their provider, an emergency contact or a mental health crisis line. This renders invisible men who are hesitant to seek health services; those who are not comfortable with using or do not have access to a smartphone; and, men who are chronically suicidal which impacts their willingness to engage with digital health technologies. These patient-users are then viewed as "bad" citizens.

Operating Model

When apps are not being sold for commercial use, such as those produced by governments or healthcare institutions, Light et al. (2018) encourage researchers to consider what other forms of revenue might figure into their operating structure. The BEACON Rx platform is an experimental research technology that is being funded by federal grant money, and therefore, providing evidence for its proof of concept is essential. Study sites and their patients receive access to the platform free of charge in exchange for their data—both clinical data, such as scores on standardized mental health assessments, as well as platform usage data, in order to demonstrate its effectiveness in the treatment of self-harm among men. These data are essential to the next phase of the platform's development, garnering interest from investors for its commercialization. Consider, for instance, the A-CHESS platform which is designed to reduce problematic substance use. Gustafson et al. (2014) first evaluated this platform for clinical effectiveness among veterans in the United States and it is now being sold commercially to addiction management providers across the country. The data initially supplied by patients and providers in the Gustafson et al. (2014) clinical trial was an essential step to establishing commercial interest in the A-CHESS platform. As explained by Crawford (2006), this emphasis on the commercialization potential of digital health technologies is made possible by a capitalist, neoliberal climate in which "good" citizens are those who engage in self-monitoring practices for the purposes of self-improvement.

Governance Structure

The BEACON Rx platform's governance structure is evident in the access and data management structure embedded within it. Access to the BEACON Rx platform is tightly controlled. While the app and Clinician Dashboard website are publicly available, in order for an account to be created, potential users must be provided with a valid Agency ID. Additionally, even when users have a valid Agency ID, all accounts must first be validated by an administrator-user who has the ability to approve or deny access to potential users. Patient-users are also not permitted to clear their data histories, functionality which can only be accessed through provider- or administrator-user accounts. Finally, while both patient- and provider-users can log out of the BEACON Rx app and/or Clinician Dashboard, it is not possible to delete their accounts, they can only be disabled by an administrator-user. This highlights the complexity of designing digital health technologies for integration in clinical care. Here, we see a distinguishing between primary and secondary default users. Despite the fact that patient-users input the majority of the information into the BEACON Rx platform, they appear to be its secondary users, with the technical architecture of the platform designed to first meet the risk monitoring and case management needs of its provider-users.

We argue that Lupton's (2013b) concept of the "digitally engaged patient" can be expanded to the imagined provider-user promoted by the BEACON Rx platform in what we are calling the "digitally informed provider." Digital health technologies are part of what Davis (2012) terms a "techno-utopia" in which health-related technological innovations are understood as normatively good and necessary to health and happiness. In this vein, data is equated with knowledge which is seen as necessarily good. The more data one has about their body (or the bodies of their patients), the more knowledge one has. More knowledge is necessarily better as it is key to the prevention of illness and disease, negating the role played by social determinants of health. This is reflective of an ideological discourse which, in the case of health surveillance, is reflective of the neoliberal emphasis on personal responsibility (Ayo, 2012). That is, the encouragement of citizens to voluntarily subject themselves to increased levels of surveillance under the guise of self-improvement is central to the neoliberal agenda (Lupton, 2014a).

These constructions of the digitally engaged patient and the digitally informed provider have significant impacts on the patient-provider relationship. Interactions that once took place in person and involved the provider physically meeting with the patient to diagnose a problem are now routinely delegated to technological solutions (Lupton, 2014a). Through the use of mental health apps as part of clinical care, providers have a greater ability to monitor and act upon their patients than ever before as a result of the volume of data that these technologies collect. The relationship to the patient, in a sense, is secondary to the relationship to the patient's data. This results in a shifting of the onus for healthcare from the provider to the patient that is characteristic of a neoliberal climate. Here, we also witness a shift from the types of knowledge that are privileged in healthcare interactions. Specifically, on the surface, we see a shift from an emphasis on the instrumental knowledge of the provider to the introspective knowledge of the patient. Instead, we argue that this perceived shift is part of the rhetoric of patient empowerment in which self-monitoring is presented as a choice that is made by the patient; however, this is, at least in part, an illusion. This is similar to what Lupton (2014c, 2016) refers to as imposed self-tracking. That is, while patients have a choice as to whether or not to engage with self-tracking practices, these choices are constrained by the consequences of non-engagement. In the case of the BEACON Rx platform, patients' choices are limited that by the fact that a possible consequence of non-tracking is the potential of receiving little to no treatment. We need to question what meaningful consent looks like when self-tracking technologies are deployed as part of routine psychiatric care.

CONCLUSION

In this paper, we have sought to provide a case example of how to effectively deploy Light et al.'s (2018) walkthrough method to answer research questions relevant to critical health communication studies. As demonstrated in this paper, this method allows for the detailed consideration of how an app's technical architecture and environment of expected use are embedded with symbolic representations of what it means to be healthy and what practices should be engaged in to maintain "good" health. It also allows for an analysis of not only the textual content of the technological artifact but also the content developed around it (e.g., websites, blogs, marketing material, employee recruitment documents) as well how its representative or stylistic elements, such as icons, colors and fonts come together to produce the conditions under which an app should be used, by whom, and to what end.

In the current example of the BEACON Rx platform, the walkthrough method allowed for a consideration of how mental health apps which purportedly allow users to take control of their own health through self-tracking are designed as tools of risk monitoring. Further, it demonstrated that the ideal (healthy) patient-user is one who is invested in his own health which he demonstrates through the dutiful tracking of his mood and self-harm triggers and is in constant contact with his provider, ready to modify his behavior to ensure his own health at a moment's notice. Similarly, the ideal provider-user is one who spends a significant amount of his or her clinical time reviewing usage data generated by patients via the BEACON Rx app to ensure that their risk factors are significantly monitored, and who is prepared to intervene as needed. This construction does not take account of the impact of the digital divide or of the impact that chronic suicidality may have on one's willingness to engage with self-tracking technologies. These users, who are rendered invisible through the BEACON Rx platform are then, within a neoliberal framework that emphasizes personal accountability for actions related to health and healthcare, viewed as "bad" citizens.

However, as explained by French and Smith (2013), "social control through health-related surveillance is neither straightforward, nor a foregone conclusion" (p. 387). The walkthrough method, as deployed in the current analysis, cannot account for patient-, provider-, and administrator-users' perceptions of mental health app use. In order to address these questions, researchers would need to employ, in addition to a technical walkthrough of the technological artifact, an interview with users or, perhaps, a guided walkthrough with users in which they explain their use of the app (e.g., Light, 2007). In doing so, researchers would be able to describe how users ignore, resist or, even enjoy, self-tracking practices, an essential component of understanding health-related surveillance in our neoliberal climate.

DATA AVAILABILITY STATEMENT

The raw data supporting the conclusions of this manuscript will be made available by the authors, without undue reservation, to any qualified researcher.

AUTHOR CONTRIBUTIONS

SH was the grant holder, conceived of The BEACON Study, and developed the BEACON platform in collaboration with CHESS Health Inc. SM conceived of the current sub-study, completed the data collection and analysis, and took the lead in drafting the manuscript. SM and SH reviewed and approved the final manuscript.

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SUPPLEMENTARY MATERIAL

The Supplementary Material for this article can be found online at: https://www.frontiersin.org/articles/10.3389/fcomm.2019.00052/full#supplementary-material

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Doing Critical Health Communication: Negotiating the Terrain of Transdisciplinary Collaboration

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In this reflective article, drawing on our personal and productive experiences with transdisciplinary research, we think about how critical health communication scholars can speak to audiences outside the discipline of communication in order to make an impact on public health and policy, health promotion, and health care delivery. We first take into consideration how we are situated in our relationship with transdisciplinary research, as well as the challenges and opportunities involved in collaborating with transdisciplinary teams. We then discuss ways we can navigate the inherent method/ological tensions in such collaborations. We argue that while the multidimensional nature of health and illness—especially in the face of skyrocketing healthcare costs and disparities—mandates transdisciplinary research and action, navigating the epistemic and methodological boundaries is nevertheless not easy. Here, we focus on how the methodological considerations of "critical" health scholarship are situated vis-à-vis the epistemic commitments in the disciplines of our potential allies and whether it is possible to collaborate in ways that can enhance the goal of social justice, equity and human rights within public health and communication.

Keywords: critical health communication, paradigms, research methods, transdisciplinary teams, rigor and bias in research

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Critical approaches to health communication are concerned with how power influences society's "cultural constructions of health and responses to illness" (Zoller, 2014, p. 270). Critical scholars are motivated by an explicitly political and ethically grounded goal of fostering social justice, equity and human rights, achieved by unmasking the sociopolitical forces that regulate and constrain the health and illness experiences of various disadvantaged, marginalized, and/or oppressed groups of people. As Zoller and Kline (2008) explain, "Critical theorizing involves deconstructing dominant, taken-for-granted assumptions about health, often with the hope of introducing possibilities for alternative, more inclusive meaning systems" (p. 271). One might say critical approaches are inherently—indeed, overtly—"biased." That is, critical health communication scholars enter into the fray with a clear personal commitment to promote progressive social change as a lever for health and development.

Critical approaches presume hegemonic structures and, importantly, the need to rectify concomitant social inequities and injustices that impact an individual's lived experiences of health and well-being. For instance, Dutta's (2008) influential culture-centered approach to health communication recognizes that certain sectors of the population have been marginalized by "institutional practices of policymakers, interventionists, and program evaluators" and the goal of critical research is to aid them in resisting and navigating a system that continues to locate them on the margins of society (Culture Centered Approach, 2017). Likewise, while feminism is not a singular belief or political position, two points of consensus are that (1) gender is a "key organizer of social life" and (2) we must take action to make our social life more equitable (Sprague, 2016, p. 3).

In other words, in critical scholarship, the stance, presumption or "bias" *against* hegemonic structures and *in support* of giving voice to and empowering those who are marginalized is acknowledged and embraced, explicit and intentional. Yet, much of the discussion about ensuring the quality and/or integrity of academic research is concerned with reducing, controlling for, and eliminating bias or what many within the social scientific tradition see as the "problematic" of subjectivity in research. Couched in terms of "rigor" (discussed below), this concern is the hallmark of traditional quantitative methods; yet debates about qualitative research methods also invoke misgivings about bias when it comes to all stages of inquiry (for discussion of debate see Grbich, 1999).

The focus on "bias" in research is troubling for critical health communication scholars because in order to have the most impact we must go beyond the realm of our own critical scholarship to collaborate with scholars and practitioners who tend to favor (social) scientific method/ologies—i.e., those that eschew "bias." If we want to positively impact the everyday lived experiences of people, it is incumbent upon us to collaborate and forge partnerships with those on the front lines, including scholars and professionals in public health and nursing, medical education and training, health education and health promotion, health psychology and sociology, and other health professional settings (Kreps, 2012). As Kotowski and Miller (2010) explain, it is through this transdisciplinary collaboration that we can "grow the field beyond its walls in the academy, increase[] its already sizable impact and help[] it mature as an important area of research into human communication processes within the health domain" (Kotowski and Miller, 2010, p. 567; see also Kreps and Maibach, 2008).

Health communication is fundamentally an applied discipline (Zoller, 2014); likewise, while not all critical research in health communication may be outright "applied," it must always be "applicable"—even as a practice of critique. It is often through such exercise (e.g., the active process of deconstruction) that alternative views of the world, innovative approaches to health and wellness, and progressive social change become possible. Ultimately, the goal is to amplify our scholarly voices and make greater impact by finding common ground, both within and outside the discipline of communication. In this way, critical health communication scholars add value to public health and policy debates and interventions through their continued commitment to praxis (Zoller, 2014).

In this article, we discuss the *challenges and opportunities* critical health communication scholars face when speaking to audiences outside the communication discipline in attempts to make an impact on public health and policy, health promotion, and health care delivery. In other words, how are we situated with regard to transdisciplinary research? How do we make the most of opportunities for collaborative research and how do we navigate the inherent tensions in such collaborations? In particular, we discuss how the methodological considerations of "critical" health scholarship are situated vis-à-vis the epistemic commitments in the disciplines of our potential allies.

METHOD/OLOGICAL DISCONNECTS

It is always a challenge to discuss the implications of paradigmatic differences without seeming to take and "us vs. them" attitude. Still, the only path to productive dialogue lies in acknowledging the sources of our tensions, recognizing the contributions of alternative perspectives, and negotiating acceptable compromises.

Thus, while thinking about the ways in which critical health communication scholars may contribute to or form partnerships with transdisciplinary research teams, we need to realize that the path is not that easy and rather fraught with multiple challenges. For instance, in his work with transdisciplinary team members including physicians, anthropologists, demographers, public health researchers and managers (Lorway et al., 2017; Khan et al., 2018; Huynh et al., 2019), Khan and colleagues found it productive but also challenging to use critical concepts. Consider a concept like "structural violence": because it refers to large-scale social and structural processes, as well as multiple and intersecting layers of disease causation, for example, it is both virtually invisible and hard to quantify. Even when an argument along this line sounds convincing, a critical scholar is often asked, "where is the evidence?" and "how do you prove it?" Transdisciplinary teams may come to embrace critical concepts—indeed, in the past 6 years, Khan and colleagues have implemented multiple research and intervention projects that address structural drivers of HIV.

We believe that a significant struggle in establishing these collaborative relationships stems from the disjuncture in the method/ological commitments of critical scholars and our potential collaborators. These challenges to *critical* research are captured in the critiques of qualitative methods[1] that are seen as inherently "biased" in that they bring elements of social constructionism in approaches to knowledge and understanding of human experience.

We want to clarify that we are not trying to conflate qualitative research methods with critical approaches. Zoller and Kline (2008) emphasize that "interpretive/critical approaches may seem synonymous with qualitative methodologies (and, alternatively, post-positivist approaches synonymous with quantitative methodologies); in research practice, however, they are not always the same" (p. 95). We start with this caveat because critical approaches are not and do not employ a specific method. As Sprague explains (2016), "We can gather information by listening, watching, and examining documents; we organize our

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[1] As McDonald (2017) explains, "Critical methods have much in common with qualitative methods, as critical researchers collect primarily qualitative data, take a subjective approach to research, recognize that knowledge is limited and partial, and seek to build connections with rather than distance themselves from research participants."

observations by counting instances of preconceived categories and/or by looking for unanticipated patterns" (p. 5). However, as Sprague's book *Feminist Methodologies for Critical Researchers* cogently demonstrates, critical scholars can certainly employ quantitative methods. Others have also discussed the use of subversive (Denzin and Lincoln, 2018) or transgressive (Lincoln et al., 2018) statistics.

This is an important distinction since recently there has been an attempt to bring quantitative research or mixed methods within critical health communication research (e.g., Thaker et al., 2018, 2019). In fact, critical scholars are generally good at drawing on and developing conceptual categories, many of which (e.g., "social capital," or "structural violence") are now used or "applied" by social scientific scholars with the help of quantifiable indicators to facilitate application and testing in intervention planning. Not surprisingly, at the 2018 National Communication Association (NCA) panel entitled "Doing Critical Health Communication: Playing with Methods," several scholars acknowledged the need and importance of using quantitative and/or mixed methods in critical research in order to speak to wider audiences including policy makers who are persuaded by quantitative data. However, participants and panel members also commented on struggling against the dominant positioning around what counts as "credible" and "reliable" data. The point is that it is certainly possible and productive for critical health communication scholars to employ quantitative methods in their research—a method that speaks to our more quantitatively aligned allies.

Nevertheless, the tension between qualitative and quantitative methods remains present and is most likely a function of on-going paradigmatic differences or conflict. That is, "methods" are traditionally presumed to have consistent and competing methodological principles, values, etc. A methodology is a "researchers' choices for how to use these methods" and "each methodology is founded on either explicit or, more often, unexamined assumptions about what knowledge is and how knowing is best accomplished" (Sprague, 2016, p. 5). More to the point, given their contrasting (some would say incompatible) metatheoretical (ontological, epistemological, axiological) assumptions, methodologies aligned with qualitative and quantitative methods have historically been at odds (Zoller and Kline, 2008).

The distinction between these paradigmatic commitments and the accompanying debates regarding (in)commensurability are well-documented (Grbich, 1999; Denzin and Lincoln, 2018; Lincoln et al., 2018). Thus, here we briefly summarize the connection to so-called "bias." (Post)positivism is a methodological approach that believes in and privileges "objectivity" or the idea "that if, and only if, we systematically and *dispassionately* observe the data of the empirical world, we can detect the lawful patterns of which they are evidence" (Sprague, 2016, p. 35). The assumption is that "'truth' can transcend opinion and *personal bias*" (Denzin and Lincoln, 2018, p. 8) and, thus, method/ologies focus on procedures "as devoid as instrumentally possible of *human bias*, misperception, and other 'idols"' (Lincoln et al., 2018, p. 135). Alternatively, critical methodologies embrace "subjectivity" starting with the "most basic ontological assumption that our perceptions of reality are constituted as subjects attach meaning to phenomena and that these meanings arise through interactions [and the] concomitant epistemological assumption… that we come to agreement about what is real intersubjectively" (Zoller and Kline, 2008, p. 93). In other words, "knowledge is not and cannot be objective because *values* are embedded into the very definition of what counts as knowledge" (McDonald, 2017, p. 3). As we articulated in the introduction, critical methodologies always already presume the *personal stance* of the critical scholar against social inequities and in favor of social justice. It would seem, then, that *post-positivist* ontological and epistemological assumptions are diametrically opposed to those associated with *critical* approaches to knowledge and understanding.

We should acknowledge here that we have been to some extent using the term "bias" ironically given that even common-use definitions treat "bias" as pejorative: "a particular tendency, trend, inclination, or opinion, *especially one that is preconceived or unreasoned*" (dictionary.com, our emphasis). When talking about academic research, the term "biased" is essentially code for *overly* "subjective" and set in contradistinction to the concept of "objectivity." As Lincoln et al. (2018) point out, bias "relate[s] directly to the concerns of objectivity that flow from positivist inquiry [and] are reflective of inquirer blindness or subjectivity" (p. 140). Thus, as in the common-use of "bias," in (post-positivist) scholarly use "bias" is also a pejorative and the influence of subjectivity is inherently called into question. Post-positivists believe that "subjectivity is an *obstacle* to knowledge" (Sprague, 2016), "is too closely aligned with the *personal agenda* of the researcher(s)" and "provides a *distortion* in the results of a study" (Galdas, 2017, p.1); it "is thought to *destabilize* objectivity and introduce subjectivity" (Lincoln et al., 2018, p. 140) which, in turn, can be seen as a "*human contamination*" (Denzin and Lincoln, 2018, p.35) (all our emphases). We, of course, are not using the concept of "bias" as a pejorative!

Most critical scholars would not necessarily see a problem with presence of "biases" or values in research since the assumption is that they are always present regardless of what kind of research one does. In short, there is no such thing as value-free science. Instead, critical scholars want these biases or values to be publicly debated so we can see whose biases and values are present and what can be done to change the status-quo (Lupton, 1994). For example, in her beautifully written book, *Hidden Arguments: Political Ideology and Disease Prevention Policy*, Tesh (1988) states: "I argue not that values be excised from science and from policy but that their inevitable presence be revealed and their worth be publicly discussed" (p.3). Packed into this single sentence is not only her attempt to problematize the ideologically rich slogan of "neutrality" in science and public policy, but also her insistence on the need to *publicly debate* the hidden arguments and values which are often more fundamental.

To be fair, we should also concede that whether "bias" amounts to an unreasonable prejudice partly depends on the eye of the beholder. Zoller and Kline (2008) critique a number of "biases" in health communication research that stem from post-positivist commitments. The problem as we see is that in discussions of research rigor, "bias" is treated as synonymous with subjectivity. And, of course, the privileging of "subjectivity" is one of the hallmarks of critical scholarship. So, how do we bridge this major gap or chasm in our approaches to research that can potentially lead to meaningful, transdisciplinary collaborations?

METHOD/OLOGICAL NEGOTIATIONS

Our transdisciplinary colleagues have already begun to find value in the contributions of critical scholars (Padgett and Henwood, 2009). Like Khan, Kline has had a long, productive, and funded collaboration with research teams that include epidemiologists, public health professionals, and physicians (Rustveld et al., 2009; Eberth et al., 2014; Kline et al., 2016). Indeed, chances of receiving government-sponsored and/or large-scale funding may be higher if we use mixed methods and have a transdisciplinary team of scholars on board (Darbyshire, 2004; Padgett and Henwood, 2009; Treise et al., 2016). The challenge is to actively work at keeping the conversation going and to persevere in mainstreaming collaborative efforts.

One suggestion for facilitating collaboration between paradigmatically different scholars comes down to adjusting qualitative methods to fit within the dominant post-positivist discourse on methodology, possibly by recuperating objectivist terminologies to justify the "rigor" of qualitative methods. For instance, in her often cited article (with more than 5,000 citations according to Google Scholar), renowned qualitative scholar and professor of nursing Morse et al. (2002) contends that qualitative scholars should return to using the terms "validity," "generalizability, "reliability," and "objectivity" rather than using Lincoln and Guba's (1985; see also Guba, 1981) terminology of "credibility," "transferability," "dependability," and "confirmability." More recently, reiterating this appeal, she elaborates that we should "develop, refine, and test analytic processes and strategies that fit qualitative inquiry while also *remaining consistent with concepts used by the larger social science community*" and maintains that "*only then will we be able to describe our methods in a way that other social sciences will comprehend and respect our research*" (Morse, 2015, p. 1,220; our emphasis).

Morse's discussion about methodological strategies for ensuring rigor (or in Guba and Lincoln's terminology, trustworthiness) in qualitative research provides valuable insight, but one has to wonder if a return to the language of objectivity would be consistent with the goals of critical scholarship. Would doing so be an invitation to evaluate critical qualitative research using traditional quantitative criteria? Would "scientists" understand Morse's nuanced reframing of these terms to accommodate (interpretive and) critical scholarship? We expect that regardless of how carefully delineated the use of these terms in the context of critical, qualitative research, the terms "validity" and "reliability" would inevitably invoke the idea of value-free scientific neutrality. At best, defending new "definitions" or applications of old terms would place critical scholars in the tenuous position of provoking readers by reopening wounds of paradigmatic frictions. Perhaps more unsettling, critical scholars would be left with the responsibility of constantly reiterating method/ological criteria that conflict with their foundational principles. That is, reversion to post-positive terminology potentially undermines attempts to challenge hegemonic post-positivist epistemologies. For instance, Maori and postcolonial scholar Smith (2012) vigorously critiques academic research and methods—mostly social scientific—that have historically been complicit in the project of imperialism by privileging Euro-centric and exclusionary ways of knowing and "discovering truth," thereby hierarchizing knowledge and delegitimizing indigenous ways of knowing and being.

As Bochner (2018) elucidates, "The trouble with inherited words like 'rigor' [or related "reliability" and "validity," etc.] is that they impede our use of other words that better express the beliefs, goals, and standards of the members of our community's way of life" (p. 361). Frankly, solutions such as returning to post-positive terminologies (and embedded values) in order to reconcile paradigmatic differences or to bolster the credibility of our research is essentially an entreaty for critical scholars to adapt to post-positivistic standards and norms. Where, then, is the middle-ground, substantive and healthy dialogue between disciplines?

Alternatively, Grbich (1999) attempts to bridge the gap between "those who have emphasized the importance of rigorous qualitative research and those who regard 'rigor' as inappropriate" by defining rigor as "the researcher's attempt to use as tight a research design as possible" (p. 61). Although Grbich does not delineate what she means by "tight" design, we read it as research design that is actively transparent, intentionally descriptive, and logically consistent. Perhaps most important, the methodological steps and the rationale behind are meticulously established and articulated before the scholar analyzes the "data."

METHOD/OLOGICAL VERACITY

The critical stance we have toward research—the presence of values and concern with sources of knowledge and knowledge production and their role in changing or perpetuating social and material contexts of health and illness—creates challenges but, hopefully, also opportunities. That is, we can find a way to speak to our potential colleagues and allies in ways that are convincing and yet maintain our commitment as critical scholars.

Let us first acknowledge that there is a distinction to be made between weak scholarship and inherent flaws with method/ologies. For instance, given the subjective nature of qualitative method/ologies, some may be concerned that qualitative researchers may try to defend interpretations by using only those examples that support the researcher's *a priori* assumptions (i.e., "biases"). Yet, that would be similar to the assertion that because *some* quantitative scholars have tried to generalize their findings based a nonprobability sampling strategy, *all* quantitative scholarship is suspect. Indeed, as Padgett (2012) reminds us, "it is fair to say that generalizability is often a problem in quantitative studies because many are unable to meet the assumptions of random sampling, normal distributions, and bounded sampling frames that underlie inferential statistics" (p. 4).

There are any number of textbooks and published studies that address the details of how to ensure the quality of qualitative research—far too many to cite here (though we've referenced some throughout this article). In addition, there are many checklists available for assessing the quality of research (see Majid and Vanstone, 2018 for a list of over 100 checklists). However, we believe that lynchpin to achieving respect and consideration for our method/ologies lies in being self-reflective about our own biases and assumptions, and transparency with regard to how they impinge on the method/ological choices we make in our research (Galdas, 2017).

Both critical reflexivity and attention to positionality are closely connected and are routinely used (or should be used) by critical scholars to interrogate their assumptions and biases (as they plan and conduct their research), including their own power positions in relation to the subject of study. This constant process of critical engagement with personal values, biases and power positions and bringing them forward for the audience to see and examine is a unique and cutting-edge contribution that critical scholars make to the world of research and methods. Indeed, in the process of doing so, they necessarily go beyond reifying methods and tools where everything including one's own biases and assumptions are open for scrutiny.

As important as the need for self-reflexivity, it is also the case that to be taken seriously outside the domain of critical theorizing in health communication scholarship, we need to attend carefully to describing and explaining our methods—i.e., the tools and conceptual categories that we use, the rationale for using them, and the contribution that they make to public health and policy and society at large (e.g., Dutta-Bergman, 2004; Zoller, 2005; Kline, 2007; Dutta and Basu, 2008; Basu, 2011; Khan, 2014; Agarwal, 2018; Khan et al., 2018).

It may seem as if critical (and qualitative scholars) are always called on to "prove" the validity of their work, but there is still a tendency among some to ignore attention to details in describing and, to some extent, following a *systematic* approach to methods. Some critical scholars, in the spirit of their critical tradition, find methods and especially the need for attention to details in describing them, rather constricting and limiting. In other words, their concern is that structured methods, by virtue of being "disciplining" in nature, run the risk of blunting critical thinking and creative ideas. Padgett (2012) recognizes that while offering a clear rationale for using qualitative methods "may seem to be an unfair burden (quantitative researchers need not do this), it is in fact an opportunity to educate the reader and convey a sense of mastery" (p. 208). As she also points out, "When the topic is appropriate, this is an easy argument to make" (p. 208). More to the point, being explicit in our methodological details helps in addressing questions, challenges, and/or suspicions head-on.

CONCLUSION

Critical health communication scholars are at an important juncture. Having made significant impact within the field of health communication, we are poised to work alongside our transdisciplinary colleagues. Given the acceleration of health inequities in the world and promises and opportunities of doing collaborative research across the globe, we must be bold and committed to moving forward on this path toward transdisciplinary research. The path of collaborative research is not easy, but opportunities exist if we are willing to speak to audiences outside our domain as well as to the new generations of critical health communication scholars who will lead future transdisciplinary teams.

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Both authors have made a substantial, direct and intellectual contribution to the work, and approved it for publication.

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PERSPECTIVE
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Blurring the Paradigmatic Edges: Navigating the Boundaries Between Critical-Interpretive and Interpretive Approaches to Health Communication Research

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Critical-interpretive health communication (CIHC) scholars take seriously the imperative to "take an ethical position" on communicative phenomenon, specifically identifying both issues of power as well as opportunities to catalyze social change (Zoller and Kline, 2008, p.93). Yet, researchers are also likely to encounter competing impulses to understand or even appreciate others' lived experiences in line with interpretive health communication (IHC) practices. My perspective essay traces the blurry edges between CIHC and IHC, and offers guidance to researchers who traverse these borders. Specifically, I articulate the key points of convergence and divergence between CIHC and IHC perspectives, and consider the questions and implications accompanying these approaches.

Keywords: critical health communication, interpretive health communication, social change, research methods, paradigmatic boundaries

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INTRODUCTION

> *"Simon says touch your nose! Now, touch your toes!"*
> *"Oooh – You're out! You're out!"*

A raucous group of second-graders pointed and laughed as I made my way to the sidelines. "I was never any good at 'Simon Says'!" I smiled at a cluster of adult volunteers offering sympathetic chuckles. There were far worse ways to conduct fieldwork, I thought. It was a warm and sunny October morning in rural Ohio. At least 75 children, parents, grandparents and caregivers, volunteers, and one friendly Labrador retriever had converged on a small town's community park for their school's first-ever "Walk-To-School Day."

The event would appear effortlessly successful to an outsider. I knew otherwise, as a member of the school wellness committee that had planned it. I had been observing the committee's meetings for my dissertation, interested in the communicative organizing of school-based health initiatives and drawn to members' passion for improving students' well-being amid challenging circumstances. The school was situated in an economically disadvantaged region known for intractable poverty, and disproportionately high rates of diabetes, heart disease, obesity, and substance abuse. My burgeoning interests in critical-interpretive health communication (CIHC) primed me to reflect on how the committee's efforts to address health disparities were constrained by a lack of material resources (e.g., funding, dedicated time, staffing, community infrastructure), and mired in power and structural issues at the national, state, and local levels (e.g., legislative mandates, inequalities in municipal and school funding).

When finding a safe sidewalk that linked directly to school proved insurmountable, the committee instead arranged for students to walk to a local park where they were picked up by buses. I felt torn between my CIHC sensibilities and my newfound appreciation of the committee's improvisational organizing as I processed the event. Did my project's critical focus limit my ability to foreground such moments? Should I instead approach my research from an interpretive health communication (IHC) standpoint? Would taking both stances toward my data be wishy-washy (at best), or (at worst) a betrayal of methodological and epistemological imperatives?

ENCOUNTERING AND ENGAGING THE PARADIGMATIC EDGES

Questions about what is gained or lost by embracing a particular methodological perspective continue to permeate my scholarship. CIHC has usefully informed my interrogations of the ideologies underpinning school-based health initiatives (e.g., Gerbensky-Kerber, 2011; Gerbensky-Kerber and Bates, 2015). However, I also am drawn to IHC in moments where I want to foreground non-critical theories (Kerber and Murphy, 2018) or highlight creativity, innovation, and incremental social change. The desire to blur the "paradigmatic edges" is not unique, nor is it exclusive to health communication (Denzin, 2010; Tracy, 2013, p. 47; Moore and Manning, 2019). Communicative phenomena present multiple facets for scholars to critique, describe, and appreciate. Clear delineations between published works utilizing CIHC and IHC are often difficult to tease out, as both investigate communication within marginalized populations and/or address issues of power, structure, and agency. The deductive writing methods and traditional monograph structures favored by many high-impact journals further obscure analytic and theory-building processes characterizing CIHC and IHC approaches (Tracy, 2012).

My perspective essay draws upon personal experiences and existing literature to trace the blurry edges between CIHC and IHC. It may seem odd to use a critical health communication forum to foreground its intersections with IHC. Yet, delineating firm paradigmatic borders ignores their socially constructed nature (Lynch and Zoller, 2015), and obscures how "researchers may productively draw from multiple, seemingly contradictory perspectives" (Moore and Manning, 2019, p. 6). For scholars seeking to traverse the CIHC/IHC boundaries, it is important to fully understand the key points of convergence and divergence between these approaches, and consider the questions and implications accompanying methodological choices.

POINTS OF CONVERGENCE AND DIVERGENCE

CIHC and IHC's close associations make sense, given important points of theoretical and methodological convergence. Ontologically, both IHC and CIHC foreground the intersubjective nature of meaning-making (Zoller and Kline, 2008). Both perspectives investigate how socially constructed understandings of health emerge from local realities, and acknowledge how knowledge claims reflect scholars' personal and theoretical standpoints, and methodological practices (Mumby, 2000; Lindlof and Taylor, 2002). My dissertation fieldwork, for example, focused on investigating the committee's relationships between "discourses-in-use (text, daily talk, and interaction) and larger social discourses (knowledge formations)" (Zoller and Dutta, 2008, p. 450). Regardless of which perspective I employed, it was essential for me to be reflexive about what my positionality (White, cis-gendered, middle-class woman) and theoretical sensibilities (narrative, feminist) primed me to notice during committee meetings and the Walk-to-School Day event.

The divergence between CIHC and IHC perspectives begins with their views on theory's role in research. Interpretive scholars traditionally begin the inquiry process with a theoretical openness toward their data, engaging in iterative movements between communicative phenomena and existing theory to develop interpretations (Tracy, 2013). CIHC scholars begin research with an explicit commitment to interrogating the operations of power, and are primed to explore related issues (e.g., agency, voice, representation, resistance) in data (Lupton, 1994; Lawless and Chen, 2019). The distinction has important implications: Whereas, IHC views health experiences as social products, CIHC researchers view the same experiences as "products of social systems and ideological processes" (Lupton, 1994, p. 58).

Research on celebrity health narratives further illustrates these differences. Beck et al. (2014) engaged an IHC perspective to argue celebrities' disclosure of personal health issues educate and inspire audiences, and influence activism. Despite using similar research methods (qualitative thematic analysis) and shared conceptual resources (narrative theory), Bute et al.'s (2016) CIHC study noted audiences perceived some celebrity narratives as "privileged, unrealistic, and even insensitive to 'real' crises of illness and disease" (p. 1015). Both studies advance theorizing about celebrity health narratives, but reach markedly different conclusions about their implications for public understandings of illness based on their perspectives.

Social justice represents another area where CIHC and IHC perspectives both overlap and sharply diverge. Although a commitment to praxis has not traditionally been central to an IHC perspective, researchers have increasingly called for interpretive research that generates social action (see arguments by Denzin, 2010). In contrast, emancipation is at the core of a CIHC research ethic (Lupton, 1994; Dutta and Zoller, 2008). Thus, it isn't surprising that both CIHC and IHC approaches have been used to study marginalized populations, the lived impact of health policies and practices, and other issues concerning health equity. The use of community-based and participatory research methods, which aim to democratize scholarly processes for participants, has also proliferated in CIHC and IHC over the last decade (e.g., Harter et al., 2011; Najib Balbale et al., 2014; Rositch et al., 2019).

However, CIHC and IHC perspectives deviate regarding the methods for achieving social justice. Although interpretive approaches illustrate lived experiences of marginalization, critical voices directly challenge the established ideologies and discursive formations creating systems of oppression. Lupton (1994) argued that failing to address the role of power undermines the transformative potential of CIHC research. Zoller (2005) similarly questioned non-critical research positioning community-oriented health promotion as empowering simply because citizens assumed responsibility for health improvements. While noting the importance of community capacity-building, she contended that ignoring the inherently political nature of health activism risked "reinforcing the logic of neoliberal economic policies that undercuts the notion of health as a public good and support for social safety nets" (p. 359).

Complicating matters further, scholars also differ in their views of how "critical" research must be to remain consistent with a social justice ethic. Lawless and Chen (2019) noted ontological and epistemological differences in criticality exist within and outside of communication studies. A case in point: Moore and Manning (2019) implored researchers to view the distinctions between critical and interpretive scholarship along a continuum based on attention to issues of power. Yet, Pasque and Salazar Pérez (2015) contended that flexible interpretations of criticality have the potential to reify the same hierarchies scholars seek to problematize, and argued for stronger congruence across the inquiry process. Clearly, the blurry edges between CIHC and IHC approaches generate entanglements for researchers to consider regarding where and how to position their scholarship.

QUESTIONS AND IMPLICATIONS

In what follows, I draw from research exemplars and my own experiences to articulate key questions and implications for scholars to consider when navigating between CIHC and IHC impulses.

Planning Research

Reflexivity is essential as scholars prepare to embark on the research process. Key questions to ask should include: What are my political and/or ethical commitments as a scholar? How do my theoretical sensibilities influence my perspective on my intended research? An IHC approach such as appreciative inquiry might be appropriate for scholars seeking to foreground practices that "sustain and enhance life-giving potential" (Ludema et al., 2001, p. 189). Yet, an assets-based perspective may not be appropriate for CIHC scholars seeking to expose a phenomena's ideological and hegemonic features (Barge and Oliver, 2003). Engaging in reflexive practices empowers researchers to design research questions aligned with their identified commitments, and determine the appropriate methodological and theoretical tools for achieving intended outcomes.

Researchers should also weigh the potential impact of their CIHC/IHC commitments on participants. Although I was familiar to members of the school wellness committee when I started my dissertation, I was hesitant to share my CIHC sensibilities with them. If my critique led participants to become dispirited about their health organizing, the trust and relationships I had developed with them could be irreparably harmed (see Carragee and Frey, 2016). Sharing my perspectives led to some initially uncomfortable conversations, but participants were ultimately reassured that the committee's practices could be made more inclusive by my work.

Collecting and Analyzing Data

Researchers at the CIHC/IHC borders should also heed Ellingson's (2009) reminder to "listen to your data… Pay attention to those flashes of insight, and they will lead you to the heart of what you need to address" (p. 79). Remaining open to the discourses and lived experiences encountered during research is essential for identifying such impulses. Reflexive interpretation (Alvesson and Sköldberg, 2009) is another useful practice that encourages researchers to engage in ongoing self-reflection as they work with data, and can help to surface potential turning points or alternative avenues for exploration. My dissertation fieldwork, for example, initially sought to highlight the school health committee's communicative practices. Observing community engagement in the Walk-to-School event, and reflecting on committee members' problematic comments about families they served sparked a new direction: How did the committee's membership practices disincentivize parental participation? And, what was the cost of excluding community voices in the wellness committee's initiatives?

Other questions emerge when determining sensitizing concepts and methods for analyzing data. Manning and Denker (2015), for example, asked whether privileging critical sensibilities meant obscuring other potentially robust theoretical frameworks. The answer is no: CIHC researchers productively couple critical and interpretive concepts. For instance, the culture-centered approach draws from both structuration and subaltern theories to interrogate localized health meanings and address disparities for marginalized communities (Dutta, 2018; see also Dutta, 2008). Other CIHC scholars have invoked narrative, problematic integration, and embodiment theories (for exemplars, see Parsloe and Babrow, 2016; Ellingson and Borofka, 2018; Field-Springer and Margavio Striley, 2018). Drawing from other theoretical perspectives broadens a researcher's interpretive repertoire, empowering them to explore how concepts can be deployed in multiple ways, and acknowledge what both CHC and IHC offer for developing knowledge claims (Ellingson, 2009; Lynch and Zoller, 2015; Manning and Denker, 2015).

Additionally, researchers must ask how critically oriented their approach to data analysis will be, and evaluate the implications of their choices. CIHC research frequently employs interpretive approaches (e.g., thematic, narrative, or discourse analyses), albeit with a commitment to power relationships (Dutta and Zoller, 2008). Yet, scholars have expressed concerns such approaches have the potential to obscure the analytic processes that make a study critical, and called for the development of more explicitly critical methodologies (Pasque and Salazar Pérez, 2015; Lawless and Chen, 2019).

Writing

As they write, scholars must ask where it makes sense to offer critique and/or description, and reflect on the potential implications of their knowledge claims. Revisiting the initial goals outlined in the planning phases is an important step, particularly when coupled with additional reflexivity about how the research process has unfolded. Scholars should consider questions, such as: What do I hope to accomplish with this research? What are the most meaningful parts of my data? What are the practical and ethical implications of sharing these results?

Defining goals related to social change is also essential. Not only do advocacy levels vary among scholars, navigating between "ideal" standards of activism and what is realistically possible (given situational and material constraints) represents an enduring struggle (Carragee and Frey, 2016). Furthermore, researchers should consider where CIHC and IHC offer complementary perspectives for engaging in social justice work. IHC approaches are useful for highlighting efforts to flip the script of dominant discourses, and identify how the lessons of successful advocacy can be applied in other contexts. CIHC approaches can identify structural ironies or paradoxes that enable and constrain agency, unmask conceptual blind spots for creating more inclusive changes, or illuminate tensions embedded within unique or promising strategies. Harter's et al. (2008) ethnographic exploration of mobile health clinics demonstrated the importance of this model for delivering health care in under-resourced communities. However, they also simultaneously noted the structural shortcomings in health care systems that necessitate such organizing.

Clarity of purpose also illuminates the possibilities for disseminating research, both within and outside of the academy: Where might it be possible to blend methodological or theoretical boundaries, or is data more suited to single-genre research accounts? What is the potential for creating crystallized texts that interweave multiple, aesthetic forms of expression to highlight the key moments and nuances in our data (Ellingson, 2009)? Recent health communication scholarship has further highlighted the success of using film, live performance, and podcasting to represent experiences (e.g., Harter et al., 2017). Thorough consideration of both traditional and new avenues for disseminating research may be useful for empowering scholars to achieve their intended goals.

CONCLUSION

Making sense of the blurry edges between CIHC and IHC approaches is important as these perspectives continue to expand. Identifying CIHC and ICH's commonalities and differences creates opportunities to enhance theoretical and methodological vocabularies, and respond to paradigmatic critiques leveled at these approaches (e.g., Lawless and Chen, 2019; Moore and Manning, 2019). The questions and implications discussed in this essay are by no means exhaustive. Rather, I hope they will spark a larger conversation about how health communication scholars can speak "within and across paradigms" to create "new spaces and ways of imagining health care" (Zoller and Dutta, 2008, p. 461).

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Problematizations in Assisted Dying Discourse: Testing the "What's the Problem Represented to Be?" (WPR) Method for Critical Health Communication Research

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In this paper I test the methodological potential of a set of six questions, called the "What's the Problem Represented to be?," or WPR approach, borrowed from the field of discursive policy analysis (Bacchi, 2012a) for doing critical health communication (CHC) research. WPR is generative for critical health researchers because it shares the goal of challenging implicit and explicit causality and correlation within discourse. I apply these questions to examine the case of legalized medical assistance in dying (MAiD) in Canada, arguing that their simplicity and capaciousness facilitate critical responses to care disparities. This particular case is edifying for CHC researchers, because ideals of good living, "dignified" death, and the role of medicine are all crystallized within legal, media, and medical discourse on assisted dying. Debating what death can or should look like depends on a clearer understanding of how the logics of embodied difference (especially ability, race, and gender) are always already stacking the odds against equal political participation in, and access to health. The WPR approach flips the "proper objects" of health-centered critical research, beginning by scrutinizing proposed solutions in order to rethink the problems implicit therein. Asking such questions as "How has this representation of the "problem" come about?," "What effects are produced by this representation of the 'problem'?" and "How has it been (or could it be) questioned, disrupted and replaced?" productively situates the researcher between the discursive practices governing health and health care praxis itself. Ultimately, I argue that the WPR method encapsulates some of the best critical perspectives from the corpus of CHC research praxis, making it a helpful tool for advancing health communication research.

Keywords: policy, health, discourse, methodology, assisted dying, euthanasia, rhetorical analysis, research

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INTRODUCTION

One key concern of critical health research is to intervene on questions of how bodies are governed by discourses of health and wellness. Attending to governmentality, however, encompasses a wide number of structural and agentic forces (Legg, 2005; Dean, 2006; Tierney, 2010), making concise interventions a challenge. Critical health communication (CHC) research demonstrates a growing record of such work. In this paper, I argue that borrowing a research technique called the "What's the Problem Represented to be?," or the WPR method, from the field of critical policy studies has productive potential for CHC researchers. Specifically, WPR is a way to identify gaps, and "lay all the cards out on the table," so to speak, in the early, or conceptual stages of critical research design. The six-question method asks such questions as, "How has this representation of the "problem" come about?," "What effects are produced by this representation of the "problem"?" and "How has it been (or could it be) questioned, disrupted and replaced?" It is designed as a means of focusing on the diverse forces of governance, their historical genealogies, and social repercussions.

As the examples I discuss illustrate, the WPR method interrogates the subject positions that are made available through practices of representing the real. In this sense, the method is not a *corrective* to existing methodological strategies in CHC research, but an *extension* and *crystallization* of those CHC techniques that disrupt and intervene on how meanings and enactments of health construct and maintain inequality. I illustrate these points of connection, using examples from the work of Davis (2010), Berlant (2010), Keränen (2007) and Daley et al. (2017). Additionally, WPR's flexibility and simplicity holds pedagogical value, since pared-down adaptations of the six questions might be helpful for introducing students to the key impulses of CHC research practice in an accessible way. The six questions can be adapted or rearranged as needed to the context of the research. Finally, because the six questions may also be applied to the alternate proposals, the WPR method offers CHC research a template for refining techniques of resistance and translating critical research into strategies for political resistance, or recommendations for changes to policy and practice. Such an effort, argues Bacchi, "signals a commitment to include oneself and one's thinking as part of the "material" to be analyzed" (Bacchi, 2012a, p. 22). Because of this, WPR serves as a means of demarcating the critical vein of health communication research from the interpretive vein, by foregrounding relationships of power in the practice of research.

By engaging with the illustrative example of the legalization of medical assistance in dying (MAiD) in Canada, the step-by-step breakdown and analysis of the questions demonstrates how WPR gets to the crux of this complicated issue. I analyze how assisted dying was problematized differently by two key documents: the Supreme Court case that brought legal MAiD into effect, and the formal legislation that enacted the assisted dying policy. By attending to what is left unspoken in assisted dying discourse, the WPR approach zeros in on the ways that shared beliefs about disability say more about the anxieties of the able, than they reflect the realities of people with disabilities. The helpful chronology of the questions exposes how shifts in problematization (Bacchi, 2016), reshaped assisted dying discourse. While it initially focused on the right to self-determination in the final chapter of life, MAiD discourse refocused on *vulnerability*, a change which ultimately disempowered the ailing patients in question. In the following sections, I justify the link to critical policy studies, provide brief background on the case of legal assisted dying in Canada, and illustrate how it can be implemented to other objects of CHC research. Ultimately, I argue that the method's value for bolstering techniques in CHC research lies in its crystallization of the most incisive impulses of a critical approach into straightforward functional terms.

Why Borrow Analytic Strategies From Critical Policy Studies?

The critical sphere of policy scholarship considers "the ways in which "problems" are constituted elicit particular forms of subjectivity, influencing how we see ourselves and others" (Bacchi, 2012a, p. 22) putting it in good company with critical health communication approaches that treat "the types of knowledges that are developed and brought to bear upon health, illness, and medical care may be regarded as assemblages of beliefs that are created through human interaction and preexisting meanings" (Lupton, 2003b, p. 50; Zoller and Kline, 2008, p. 93). Within the field of critical health research, one of the key challenges that researchers are presented with is the breadth of institutional and structural forces shaping health discourse and practice. This is particularly true of key areas that have gained traction since the publication of Zoller and Kline's comprehensive review (Zoller and Kline, 2008), including the study of health policy as a critical communicative process and the development of context-sensitive models of health promotion, for which it is necessary to give in-depth attention to the diversity of structural and agentic forces at play. Furthermore, while there is a wealth of models for doing strictly interpretive work, as the editors of this research topic suggest, "doing" critical work, often deviates from interpretation. I argue that because of the applied nature of policy approaches, the strategies outlined here facilitates research with an eye to critical *praxis*, to intervening in the practices that reinforce health disparities.

Bacchi's approach to discourse analysis, which she terms a "policy-as-discourse" approach, scrutinizes presumed causality in the policy process. In other words, she calls on policy analysts to view policy not as producing a response to an objective problem, but rather, drawing on Goodwin (1996, p. 96), "as a discourse in which both problems and solutions are created" (Bacchi, 2000, p. 48). In this formulation, policy is treated not only as a tool of governance, but also as a social text providing fruitful grounds for interpretation. More specifically, she posits that policy analysis cannot set out to interpret or critique social problems of any kind, without first challenging how policy defines the problem itself to begin with. "Problems," explains Bacchi, "are "created" or "given shape" in the very policy proposals that are offered as "responses"" (Bacchi, 2000, p. 48). That is, policy (often erroneously) names and foregrounds the problems it proposes to solve. Disability policies, for example, frequently begin with the assumption that people with disabilities are the "problem" to be solved (Fulcher, 1989). Likewise, policies addressing the status of women in the workplace may fixate on lack of training as being the ""problem", responsible for "holding them back,"" when the problem is not women at all, but institutional gender bias (Bacchi, 2012a, p. 21). Bacchi's succinct reversal sets the researcher up to pose incisive questions and challenge presumed causalities at play in a wide range of social issues.

As I illustrate in the examples that follow, critical and interpretive policy analysis shares many of critical health communication's guiding affinities. More importantly, however, Bacchi's approach overlaps with critical scholarship that welcomes discord between conflicting accounts and views, encouraging researchers to keep open the "fertile tensions" between perspectives (Bacchi, 2000, p. 55). In this sense, the approach aligns with those critical communication scholars who welcome "dissensus," and are concerned "with the privileging of interests by particular constructions of reality" (Deetz, 2001, p. 15; Zoller and Kline, 2008, p. 93). Beyond the inclination toward challenging the central tenets of discursive texts, this vein of critical policy analysis is invested in interrogating the function of broader social processes at play in perpetuating the "problem" at stake. This, of course, is exactly what many critical health researchers embark on when they begin by rejecting the presumption that "health" is a stable category on which promotional campaigns, care practices and individual regimes of prevention are built. Health, as Metzl and Kirkland argue, is not a "a fixed entity that can be transported from one setting to another" (Metzl and Kirkland, 2010, p. 1) from the rich to the poor, for example. As CHC researchers know, policy and practice that assumes the stability of the problem itself misses the point. While this conviction is shared by critical policy studies and critical health communication, what does such analysis look like? Likewise, how should researchers go about zeroing in on an object for analysis that can yield impactful results?

An Illustrative Case: The Legalization of Assisted Dying in Canada

In the last twenty years, there has been an uptick in the number of jurisdictions debating the right to die worldwide. Belgium, Colombia, Luxembourg, the Netherlands, Switzerland, as well as six states in the United States (Oregon, California, Colorado, Montana, Vermont, and Washington) now all have some form of legal assisted dying protocol in place (Emanuel et al., 2016). Whether framed as assisted suicide, or medical assistance in dying, an increasing number of people at the end of life are making new demands of clinical care systems and the legal jurisdictions governing them. While the end of life is still broadly understood as a private affair, to be attended only by close family and health care workers, it is increasingly common for the dying to speak openly about their experiences (Van Brussel, 2014; West, 2018). Patients are no longer kept in the dark about a terminal prognosis, as was the norm in past decades, and are now encouraged to participate in the decision-making processes at the end of life (Walter, 1994). MAiD is an instructive case among these broader shifting end-of-life practices, because it provides an alternative option among the "increasingly flexible cultural scripts" (Timmermans, 2005, p. 993) in the final chapter of life. Despite this flexibility, as Keränen (2007) study of institutional discourse surrounding code status demonstrates, the unique challenges of end-of-life discussions are such that patients, families, and physicians and caregivers often feel that communication breaks down at the expense of patient experience. Given the high stakes associated with it, and the propensity for end-of-life discourse to create communication breakdown, MAiD is fertile ground for CHC analysis.

In 2016, Canada followed the US states and growing number of other countries worldwide that permit assisted dying. What makes the case of legalization in Canada such a compelling one is that in addition to reclassifying voluntary assisted dying from crime to care, the transition catalyzed frank and open discussions about the social function of medicine itself, and even more generally, what makes life liveable. Couched in these deliberations are deep concerns; actors in the debate have had to examine whether legalizing forms of suicide or euthanasia will reshape the fabric of social life altogether. Within the context of medical assistance in dying in Canada, the push toward a "permissive system" in which MAiD would be allowed in certain circumstances was understood as a way to limit suffering at the end of life. A key Supreme Court of Canada case, *Carter v. Canada*, which set the precedent for legal MAiD was centered around plaintiff Gloria Taylor, a woman diagnosed with amyotrophic lateral sclerosis (ALS) at age 61. This ruling focused on alleviating pain for those "who are suffering intolerably as a result of a grievous and irremediable medical condition" (Carter v. Canada (Attorney General), 2015, p. 6). The *Carter v. Canada* ruling found that the previous ban on assisting suicide actually deprived some people of life, since some may take their own lives prematurely for fear that they will be incapable of doing so when their suffering eventually becomes intolerable. This gesture reframed the right-to-die issue by positioning it as a violation of the guarantee of "the right to life, liberty and security of the person and the right not to be deprived thereof…" (Parliament of Canada, 1982) entrenched in the Constitution of Canada. At this stage in the policy process, the existing laws were identified as an obstruction to the guarantee of the right to a life without suffering. "End-of-life suffering," then, was considered the central problem at the heart of the issue.

Not unexpectedly, the proposed legalization of assisted dying set off contentions. Between 2012 and 2016, when proposed laws and a high-profile case in the Supreme Court were contemplating the decriminalization of assisting in the death of a terminally ill person, medical assistance in dying was bitterly debated in the Canadian media. Some of the most vocal opponents of MAiD argued that "social permission to die can evolve into social pressure to die" (Wente, 2015, para. 9). These fears fixed on the possibility that legalized MAiD might create a "slippery slope" whereby in addition to allowing terminally ill individuals to request MAiD in their final moments of life, the social climate might evolve into a point where the elderly could make such requests in order to avoid becoming a burden on their children. The figure of vulnerability loomed justifiably large over the controversy, particularly where the question of disability was present. Many wondered how any such laws could protect people with disabilities from abuse. Furthermore, some questioned how legalization of MAiD would address mental illnesses including Alzheimer's and depression, particularly where they might intersect with advanced old age or terminal illness (Chochinov et al., 2015).

During the deliberative processes, in addition to the moral debates about the permissibility of MAiD, the social function of medicine itself came into question. One group of doctors contended that no doctor who agreed to provide MAiD could at the same time "fulfill their role as protectors of the public and of life…" (Physicians Alliance Against Euthanasia n.d.), and that any procedure shortening life violated the Hippocratic

Oath, and could therefore not constitute medicine at all. Van Brussel's analysis of news coverage of euthanasia in Belgium classed such arguments as "medical-rationalism," in which the strong belief in medical progress, and a focus on the technical dimension obscure the more existential and personal significance of death and dying (Seale, 1998, p. 77; Van Brussel, 2014, p. 17). Other care providers were more invested in revising the central tenets of medicine to accommodate an assisted dying protocol. Those who were willing to provide assisted dying contended that contemporary care practices should be revised to incorporate more flexible and patient-centered end-of-life options, including withdrawing lifesaving treatment, palliative sedation, and assisted dying procedures. Following this discourse, the role of doctors, drugs, and the "tangle of tubes" (Armstrong, 1987, p. 565) that envelop the dying patient in the medical sphere take a backseat to the patient's own needs and wishes. The gulf between these disparate approaches were as wide as ever as the government was tasked with writing legislation that would comply with the Supreme Court's mandate that MAiD protocols could provide relief for people suffering intolerably from a "grievous and irremediable illness," (Carter v. Canada (Attorney General), 2015) while responding to concerns about abuses of the vulnerable. The breadth of arguments during this period illustrated how beliefs about the right to die and about what constitutes dignity in death were shifting.

In June 2016, legislation legalizing assisted dying passed in parliament and a set of restrictive eligibility criteria stipulated that the patient's death must be "reasonably foreseeable" to access MAiD (Nicol and Tiedemann, 2016). Many argued that this restriction unnecessarily excluded people who would suffer at length as a result (McLeod, 2016; CBC News, 2017). However, even many of those in favor of legal MAiD argued that there is no such thing as a "reasonably foreseeable" death. Furthermore, the restriction proved controversial within the context of disability. First, the matter was complicated by the difference in types of disability: those with lifelong conditions, and those who develop degenerative neuromuscular conditions later in life[1]. Secondly, advocacy groups and representative bodies were sharply split on the implications of access to MAiD for disabled people. Both sides argued that the other would foster exclusion and undermine equality for people with disabilities. For some, like bioethicist and disability rights activist Jennifer Johannesen, the reasonably foreseeable clause is considered a necessary safeguard to protect disabled people and those who suffer "from poverty, from disenfranchisement, from exclusion, from poor health care," and "poor palliative care" (Johannesen, 2016). The attorneys and plaintiffs in the Supreme Court case, spoke out against what they understood as a reversal of the precedent set by the case, arguing that denying MAiD to those without terminal illness or imminent death was "discriminatory" and "infantilizing" to disabled people (Lunn, 2016), would strip the autonomy granted to all Canadians by the *Carter v. Canada* Supreme Court ruling, and "trap people in their suffering" (McLeod, 2016). The "reasonably foreseeable" clause clearly emerged as the biggest point of contention at the center of the debate about the permissibility of assisted dying. This particular phrasing exposed deep anxieties about the temporal dimension of death and the role of medicine therein. Following Keränen's phrasing, it also holds the potential to "invite reflection about what life means to a patient, what death means, and what conditions are absolutely imperative and absolutely intolerable" (Keränen, 2007, p. 200).

Finally, in seeking to account for some of these concerns, the resulting amendment to the criminal code holds many clues about the "ideational logics" (Bacchi, 2012a, p. 21) shaping how Canadians understand dignity in death in the era of medicalization. The case is instructive for CHC researchers in that it served as a discursive forum for deliberating on shared Western ideals of medicine and autonomy. It presented, however, a complex set of conflicting beliefs and problems that proved challenging to parse. In the following section, I illustrate how the WPR method offers productive strategies for teasing out a critical analysis of this particular case, as well as theorize the potential of each WPR prompt to address concerns from other CHC research contexts.

THE WPR METHOD

On the surface, the six questions that constitute the WPR method might resemble a journalistic approach, one that considers "what, when, where, why, and how." However, despite their simplicity, the questions push the researcher to theorize across contemporary practices, *and* historical precursors—not always an easy or straightforward task. A critical approach can use WPR to consider how "particular problematizations favor certain solutions and preclude others" (Fairclough, 2013, p. 183; Bacchi, 2012b) from the outset, and identify the next steps of the research design. In other words, WPR is a way to identify gaps, and "lay all the cards out on the table," so to speak, in the early stages of critical research. It is a way of homing in on opportunities for making critical in-roads. The questions are as follows:

1. What's the "problem" (for example, of "problem gamblers," "drug use/abuse," "gender inequality," "domestic violence," "global warming," "sexual harassment," etc.) represented to be in a specific policy or policy proposal?
2. What presuppositions or assumptions underpin this representation of the "problem"?
3. How has this representation of the "problem" come about?
4. What is left unproblematic in this problem representation? Where are the silences? Can the "problem" be thought about differently?
5. What effects are produced by this representation of the "problem"?
6. How/where has this representation of the "problem" been produced, disseminated and defended? How has it been (or could it be) questioned, disrupted and replaced? (2012, p. 22).

In identifying genealogical threads connecting problematizations to their radically contingent historical precursors, WPR facilitates imaging how social problems were once thought of otherwise and how they might be more

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[1] No one with a mental disability or illness is allowed access to MAiD under current laws.

progressively reimagined in the future. The WPR's reframing practice invigorates the possibilities for engaging a Foucauldian biopolitical perspective in CHC research strategies.

As the following examples from the case of MAiD illustrate, policy seeks to identify a singular problem in order to articulate a solution. Bacchi argues in reference to Australian health practices, this orientation is typical for policy, which is "conceived as a tool of governance to redress what needs fixing up in society" (WPR: What's the Problem Represented to Be?, 2014). Such an orientation is a *reactive* approach, because it is predicated on "fixed and identifiable societal problems" so as to name solutions in policy. For these reasons, argues Bacchi, we are governed *through the problematizations themselves*, rather than directly through policy, since it is in problematizing particular issues that policy makers enact their influence over society. By contrast, the six questions are strategically ordered so as to *upset the naturalization* of a social problem, thereby opening up room for critical intervention. In each of the following sections, I explore the goals of these questions in turn and test their capabilities for unpacking the trickiness of MAiD legislation in Canada. I also draw comparisons with existing approaches in the history of CHC research to illustrate how it meshes well with established strategies in critical health research.

HOW DOES WPR TRANSLATE TO A CRITICAL HEALTH RESEARCH?

What's the Problem Represented to Be?

The first question is intended to make visible the implicit problem representation within a specific policy. This, Bacchi explains, is the very crux of the method, since "what we propose to do about something reveals what we think needs to change and hence what we think is problematic" (WPR: What's the Problem Represented to Be?, 2014). Beginning with the WPR method's critical orientation, the first question sets the researcher up to move beyond face value assessments of social problems in order to unearth deeper ideational logics at play in the discourse at hand. By first naming the problems and their proposed solutions outright, CHC researchers can next examine deeper cultural contexts. The gesture seems simple, but it productively situates the researcher between the discursive practices governing health and health care praxis itself.

For example, Shapiro (1981, 2012) has drawn on this gesture of problematization to examine a case of health policy in Australia. Policy analysts on a government contract were tasked with addressing the high infant mortality rate among the aboriginal population. They had concluded that the disproportionate deaths were the result of the "semi-nomadic life of some of the aborigines" (Shapiro, 1981, p. 186). This explanatory politics, argues Shapiro, treats the assumption that indigenous people should adapt their mobility patterns to Western sedentary medicine as unproblematic. The fruitful reversal of problematization posits that the problem may in fact be with the Australian government's failure to adapt its delivery facilities to aboriginal migration (2012, p. 61). In producing a problematic aboriginal subject, the policy process of which Shapiro is critical presumes indigeneity to be always already engaged in "risky" behavior. By shifting problematization to the strategies of governance, the focus on a failure of maternal healthcare to adapt to migration opens up possibilities for critical examinations of the production of "governable subjects" (Mennicken and Miller, 2012) by the practices of governance themselves.

The central "problem," then, for pro-MAiD organizations such as Dying With Dignity Canada is prolonged end-of-life suffering. Sixteen months after the Supreme Court ruling, however, when the final piece of policy passed legal MAiD into effect, the problem was represented otherwise. The bill amending the criminal code used different language to represent the problem, shifting the focus of problematization. The "robust safeguards" (Wilson-Raybould, 2016, chap. 3) intended to protect some individuals from abuse took the form of an eligibility clause that focused on the temporal dimension of death. Specifically, it hinged on death's imminence as a precondition to accessing assisted dying. The MAiD legalization bill stipulates that assisted dying be provided for those with a "grievous and irremediable medical condition" which had to meet the criteria of their "natural death has become reasonably foreseeable" (Nicol and Tiedemann, 2016; Wilson-Raybould, 2016).

In short, as the legalization of MAiD passed from Supreme Court precedent to formal legislation, the language of the permissibility of the practice shifted from a focus on alleviating suffering, to expediating inevitable death. The new language was controversial, with many doctors decrying the "reasonably foreseeable" clause as meaningless from a clinical standpoint and therefore difficult to implement. This language of foreseeability is borrowed from civil and criminal law and relates to "risk, harm and the law of negligence" (Canadian Association of MAID Assessors and Providers, 2019, p. 3). As such, this language reflects the discursive nature of the legislation being an amendment to the criminal code, in contrast to something like health care policy. In its focus on culpability rather than care, the problem at the heart of MAiD is represented to be the potential abuse of vulnerability. The role of the state is therefore implied to be in the protection of the vulnerable. In the same gesture, the patients in question, those nearing death with some measure of "foreseeability" are cast as inherently vulnerable subjects. WPR's Question 1 helps to lay bare how a discourse of self-determination pivoted to one of vulnerability.

What Presuppositions or Assumptions Underpin This Representation of the "Problem"?

Bacchi's second question seeks to unearth the ideational logics informing a particular problematization. For those familiar with critical methodologies in health communication research, this question can serve as a gateway to a familiar set of concerns. That is, the question links specific problematizations to the conceptualizations of society that constitute them. Bacchi cites Foucault's *Madness and Civilization* as influential in her conception of WPR's second question (Foucault, 1965; WPR: What's the Problem Represented to Be?, 2014). Question 2 encourages an approach similar to Foucault's in that it seeks cultural precursors to social phenomena, without relying on linear or causal historical argument. In focusing on discourse and social practices surrounding madness in history, Foucault was able to see how madness was thought about and how it came to be *problematized*, in this case for the first time. This focus on discourse and social practice offered a much clearer picture of madness than any other account from or about this era of history. Exposing the ideational logics, or "assemblages of beliefs" (Lupton, 2003b, p. 50) focuses the researcher on how interactions produce the kinds of body knowledges that shape the subject. In this sense, the method aims to articulate a certain measure of generalization beyond local concerns and interpretations. Like critical health research, in the WPR method "[p]articular persons and situations are artifacts used to understand the system of meanings through which particular persons and situations are composed and connected to the larger sociocultural context" (Deetz, 1992, p. 85; Zoller and Kline, 2008, p. 94). This means that the researcher can put cultural and ideological influence under the microscope, interrogating commonly accepted authoritative knowledges that determine what is "within the true" in our society (WPR: What's the Problem Represented to Be?, 2014).

As an example of how Question 2's approach is done well, consider Davis' study of obsessive-compulsive disorder (OCD) (2010). Like WPR's second step, Davis considers the styles of problematization that shape shared views. Davis contends that most studies of the disorder wrongly presume that OCD is a "universal and static" disease attributable to a particular pattern of neural physiology. Furthermore, explanations for a massive swell in the number of reported cases (from an estimated 0.005 to 0.5 percent of the general population in 1970 to one of the top four mental disorders in the world), Davis argues, tend to rely on the "'it's always been around' myth" (Davis, 2010, p. 124) the justification of which is unconvincing. In this instance, the DSM-V serves as the most commonly accepted, authoritative knowledge about OCD, but as Davis points out, the manual falls back to overly reductionist views, ignoring how "our definitions of mental health can be driven by complex biocultural factors" (Davis, 2010, p. 130). In attending to presuppositions and assumptions about the disorder, Davis illustrates how such an approach can expose where and how the medicalization of human behavior can shift perspectives.

Most critical approaches health communication share in the conviction that "our perceptions of reality are constituted as subjects attach meaning to phenomena and that these meanings arise through interactions" (Zoller and Kline, 2008, p. 93). Although myriad discursive forces shape the rights and rituals of health and wellness, CHC research need not account for all such influences. This second question of the WPR method is productively bounded. That is, the phrasing of the question encourages research design that zeroes in on select historical precursors, and the relationship they bear to contemporary phenomena. Cousins and Hussain (1984, p. 4) argue that "in accounts of governmentality, intelligibility not exhaustiveness is the key. What is sought is not an exhaustiveness of evidence but an intelligibility of problematizations..." (as cited in Osborne, 1997, p. 175). Anchoring the scope of inquiry to only those presuppositions which underpin *this* representation, advantageously fixates on one of the ways in which bodies are governed through discursive practice. WPR's Question 2 encourages a mode of interpretation that exposes what lies beneath surface-level assumptions about health and wellness. This question provides a fresh impetus to dig deeper into the origins and evolution of current iterations of the topic at hand.

In the case of MAiD in Canada, the problematization of vulnerability is underpinned by the view that we are (or should be) autonomous and invulnerable throughout life, that a good and healthy life is contingent on this invulnerability. The legislative framing fixated on a "reasonably foreseeable" death as a condition of its legal permissibility, a gesture which was intended to protect vulnerable individuals from having their lives cut short by accessing assisted dying.

By contrast, the global right-to-die effort pushing for the legalization of assisted dying worldwide, typically focused on patient experience, alleviating unnecessary suffering and giving individuals the right to self-determination in the final stage of life. Question 2 of WPR exposes the ways that a fixation on the vulnerability of potential MAiD patients inadvertently reifies the view that good healthy living necessarily excludes any kind of dependence or vulnerability.

How Has This Representation of the "Problem" Come About?

Following Foucault, the third question in the WPR method unpacks the genealogy of the implied problem. Within the context of critical policy analysis, this question serves to articulate the "players" involved in producing the policies themselves. Question 3 offers the opportunity for "consideration of the contingent practices and processes through which this understanding of the "problem" has emerged" (Bacchi, 2012a, p. 22). Analysts examining the origin of a problem representation might examine policy briefings to explore how the approach to the problem might have evolved or mutated over time. Question 3 is one strategy for avoiding the pitfalls of a presumed linearity that often befalls the problem definition and agenda setting stage of policy making (Barbehön et al., 2015). This critical orientation is intended to scrutinize the power relationships at play within policy networks. At this stage, a WPR approach considers which actors have shaped a given discourse or policy and how this has given shape to the coherence of a particular problematization.

Question 3 might best be explained with the example of abortion policy. While abortion was a common method of birth control for many years in nineteenth century Western nations, Britain's *Offenses Against the Person Act* of 1861 first proclaimed the illegality of the practice (Parliament: House of Commons, 1861; Sauer, 1978; Chamberlain, 2006). Therefore, 1861 serves as a point in time in which the problematization of abortion changed; at this moment abortion became a legal, criminal concern. Such a perspective casts *knowledge as the product of a struggle*. During this era, the emergence of modern medicine as a profession, the act was promoted by doctors who were eager to assert their authority over women's health. Bacchi argues that particular problematizations gain authority through struggle. The fact of the illegality of abortion was due in part to the struggle of the new profession of medicine against other unregistered practitioners (WPR: What's the Problem Represented to Be?, 2014). This mode of thinking illustrates the radical contingency of knowledge on differential power relationships.

Attending to the underlying genealogical strata of problem representations offers emancipatory strategies for critical health researchers. In questioning "taken-for-granted assumptions" about who participates in political debates and policy processes, this aspect of the WPR method mimics the focus on agenda setting present in rhetorical analyses such as Perez and Dionisopoulos (1995) work on AIDS (Zoller, 2005), gendered analysis of the U.S. Department of Health and Human Service's Healthy People 2010 initiative, and Gillespie's (2001) analysis of asthmatic medicaid patients under managed care. Bacchi's third question aids in developing "a sharpened awareness of the forms of power involved in the shaping of problem representations" (Bacchi, 2012a, p. 23). In this sense, by calling the researcher to attend to knowledge-making practices, the WPR method holds potential for better understanding the communicative processes that inform the governance of health.

In Canadian assisted dying discourse, the focus on the "problem" of vulnerability came about in part as a result of its being conceptually linked to disability. The first federal right-to-die case was filed in 1993 by Sue Rodriguez, a woman with ALS who wanted access to medical assistance in dying (Rodriguez v. British Columbia (Attorney General), 1993). The following year, Robert Latimer, convicted of killing his severely disabled young daughter Tracy, lost his case subsequent appeals for "compassionate homicide," and served sixteen years in prison (CBC News, 2010). These instances were widely covered by the press and set a tone in the public imaginary in which the possibility of "allowable deaths" always carried the risk of endangering children like Tracy Latimer, or of devaluing the lives of people with disabilities. When plaintiffs in the *Carter v. Canada* Supreme Court ruling made arguments in favor of legalizing medically assisted death, their disabilities and disabling conditions were necessarily linked to these prior cases and their associations with vulnerability and the potential for abuse (Carter v. Canada (Attorney General), 2015). So, while the plaintiffs themselves understood MAiD to be a means of articulating their right to self-determination, many other groups including some disability rights groups and physician associations voiced concerns of abuse. Because of this, the ensuing legislation ushering in Canada's permissive system remained focused on the issue of vulnerability. The bill's preamble states: "Whereas it is important to affirm the inherent and equal value of every person's life and to avoid encouraging negative perceptions of the quality of life of persons who are elderly, ill or disabled; Whereas vulnerable persons must be protected from being induced, in moments of weakness, to end their lives" (Wilson-Raybould, 2016). This language positions disability as always vulnerable. That the following clause further links disability to weakness and vulnerability and suggests that people with disabilities are more susceptible to being persuaded to seek out MAiD by others. Since the previous two questions helped point out this shift in problematization, we might consider how this protectionist language is not inevitable, but rather the product of ableist paradigms of thought that seek to reinforce the *invulnerability* of able-bodied people.

What Is Left Unproblematic in This Problem Representation?

After tracing the discursive genealogy of problematization, the WPR method asks the researcher to consider what is left unspoken in the given discourse. This intervention is a way to arrive at the question: "Can the "problem" be thought about differently?" (Bacchi, 2012a, p. 22). Having contextualized and deconstructed what has been made central by a policy or discursive text, the fourth of Bacchi's six questions turns to what is left unspoken. Following this procedure encourages "careful scrutiny of possible gaps or limitations in this representation of the "problem," accompanied by inventive imagining of potential alternatives" (Bacchi, 2012a, p. 23). By asking what other interpretations there may be of the problem, Question 4 can be answered by taking a comparative approach, looking across time, or cross-culturally to see how issues have been problematized differently. Drawing on Foucault, Bacchi encourages the researcher to scrutinize and identify the "specific combination of practices and relations that give a problem a particular shape in a particular time and place" (WPR: What's the Problem Represented to Be?, 2014). Here Bacchi's approach shows its close affiliation with critical perspectives in communication, including those drawing on the cultural studies tradition that emphasize the "culturally situated nature of health communication interactions and processes" with reference to the structures of power that shape them (Zoller and Kline, 2008, p. 97; Dutta, 2008; Mokros and Deetz, 2013).

In attempting to resolve the matter the assisted dying in light of multiple competing public voices on the issue, the bill amending the criminal code was conceived as a means of "permitting access to medical assistance in dying for competent adults whose deaths are reasonably foreseeable," while striking a balance with the "autonomy of persons who seek medical assistance in dying, on one hand, and the interests of vulnerable persons in need of protection and those of society, on the other" (Wilson-Raybould, 2016). Autonomy, here, is understood as a set of rights, universal to all those patient/citizens subject to care under Canada's universal health care system. Furthermore, it has been informed by the legacy of abortion rights which established a notion of personal autonomy that encompassed "control over one's bodily integrity free from state interference" (Rodriguez v. British Columbia (Attorney General), 1993; R. v. Morgentaler, 1993; Carter v. Canada (Attorney General), 2015). These linkages to abortion rights seem to gesture to MAiD's liberatory power, by granting dying patients greater self-determination at the end of life. Left unspoken however, is that the power to determine the reasonable foreseeability of death is still granted to physicians. Although intended as a safeguard, in leaving the responsibility for the decision to permit MAiD with the medical establishment, the law reifies its status as ultimate authority. Challenging the ultimate authority of medicine over the final moments of life had been one of the primary goals of the right-to-die movement that fostered political momentum for MAiD legislation. Linking vulnerability to disability as the policy does, exposes how as disability scholars such as Garland-Thompson have noted, disability is constructed as a "repository" for social anxieties about "vulnerability, control and identity"

(1997, p. 173). In this sense, the legislation which is intended as a protectionary measure against abuses of vulnerable people, also works unintentionally to perpetuate the notion that people with disabilities are necessarily vulnerable, and by extension, that able-bodied people are *invulnerable*, or at least unlikely to be vulnerable in the same ways.

Like other established critical and interpretive techniques in health communication, this question asks the researcher to consider how the construction of problem and solutions may be "deflecting attention from other (marginalized) interests" (Zoller and Kline, 2008, p. 102). Lauren Berlant's study of obesity discourse might be understood as taking the same methodological orientation to health as does WPR's fourth question (Berlant, 2010). What's missed in all the efforts to condition people to make better choices about their health by eating well and exercising, she argues, is that racialized poverty and exploitative capitalist work culture shape day-to-day health practices more than does any kind of will power or autonomy. Such an approach lay bare the fiction of neoliberal invulnerable self (West, 2018), whose autonomy and self-determination are expected to make or break the push for achieving or maintaining healthiness. As Berlant's study illustrates, health-centered critical research is attuned to challenging the problematization of certain health practices. Question 4 carries the imperative to revisit the political nature of health discourse. Attending to the silences in a particular mode of problematization refocuses attention on *how* and *why* some subjects are problematized while others are not.

What Effects Are Produced by This Representation of the "Problem"?

Question 5 of the WPR method addresses representation, meaning, and effect. In adapting this question to the context CHC research, it is evident that it can be used to examine how a particular health discourse, practice or process may contribute to health and care disparities. This question is intended to stimulate "considered assessment of how identified problem representations limit what can be talked about as relevant, shape people's understandings of themselves and the issues, and impact materially on people's lives" (Bacchi, 2012a, p. 22). Such an approach is key to critical research's insistence on considering the material and lived effects that discourse, policy or governance may have on the subjects in question. It positions the researcher to think holistically about who stands to risk the most when communicative health practices are enacted in society, whether at the level of local communities, or global populations.

Representing vulnerability as the central problem at the heart of MAiD legislation has the effect of reproducing a version of healthy liberal subjectivity that is autonomous and invulnerable. As Bacchi suggests, such an analysis is not conceived as a cause and effect relationship, but rather examines how we are governed through problematizations, a process which has the potential to constitute us as governable subjects. While it is of course critical that people be protected from ending their lives prematurely, the legislation itself has been denounced for excluding access to many of the individuals that MAiD was understood to be assisting, including, some have argued, the original plaintiff on the Supreme Court Case, who lobbied for the legalization of MAiD in the first place (McLeod, 2016). Immediately following the passage of the Criminal Code Amendment (Bill C-14), a young woman with spinal stenosis named Julia Lamb filed a court challenge to the bill on the basis that it discriminated against people with disabilities. In a sense, the bill and its restrictions might be understood as protecting ableist conceptions of good living, where life is worth living up until it isn't, where bodies are healthy and able until disability creeps in and a medical authority predicts that death is reasonably foreseeable. Herein lies the value of Bacchi's fifth question. It scrutinizes how political and discursive formations can construct limits imposed on what can be thought and said (WPR: What's the Problem Represented to Be?, 2014), and, particularly in the case of assisted dying discourse, calls attention to the impact such practices can have on conceptions of life and death (Dean, 2006).

Critical health communication researchers and other scholars attending to medicine from a critical-social perspective frequently attend to the material consequences that social systems of power may have on peoples' lives, whether as a result of inequities produced by gender, class, race, or other differences (Waitzkin, 1991; Briggs, 2002; Lupton, 2003a; Murphy, 2012). Having pushed the researcher to articulate the underlying premises of a problem's representation, examine its emergence in practice and process, and scrutinize the gaps in its logics, the fifth question in the WPR method's procedure pushes the researcher to move toward the political implication of discursive formations. Pairing this consideration with the earlier steps in WPR analysis encourages an outlook that leaves the complex plurality of health care discourse intact. To borrow from Zoller and Kline's commentary on the work of Nadesan (2013), the question invites a research practice that will "address relationships among materiality/biology, culture, and identity, without reifying these complex concepts" (Zoller and Kline, 2008, p. 106). Finally, Question 5 primes the researcher to next consider how such a problematization circulates in popular discourse.

How/Where Has This Representation of the "Problem" Been Produced, Disseminated, and Defended?

Having called on the researcher to lay the groundwork necessary for critical intervention, the sixth question turns toward dissemination and resistance. The sixth question asks: How/where has this representation of the "problem" been produced, disseminated and defended? How has it been (or could it be) questioned, disrupted and replaced? (Bacchi, 2012a, p. 22). This question, the final of the six, allows the researcher to consider "actors" such the media as co-constitutors of problem representation. It is "explicitly concerned with resistance" and how "challenges to pervasive problem representations take place (WPR: What's the Problem Represented to Be?, 2014). This question works in tandem with Question 3 in order to imagine alternatives and to "destabilize taken-for-granted truths" (WPR: What's the Problem Represented to Be?, 2014). With particular relevance to analyses that focus on media messages, the approach is not concerned with intentional or strategic framing, or misleading shaping of messages, but rather about the subject positions that are made available through practices of representing the real. Bacchi is adamant that the Foucauldian origins of the WPR method do not preclude resistance, but rather encourage it. Citing the importance of the medical definition of homosexuality to the gay movement, Foucault argues that although discourses of medicalization may consist in forces of oppression, they can often also precipitate means of resistance as well (Foucault, 1998, p. 168). Although the standing medical definition of homosexuality was oppressive, it served as a point of departure for resistant political intervention. A parallel contemporary example lies in trans politics of resistance. While the DSM IV (the Diagnostic Statistics Manuals for "Mental Misorders") pathologized trans bodies through the language of deviance (Bevensee, 2014, p. 100), its inclusion in medical manuals can help trans people access gender confirming surgeries through their insurance coverage (Corneil et al., 2010), and thereby carries the potential for such resistance to normalizing regimes of oppression. The sixth question's critical focus on the role of representation attunes the WPR method to honing alternative political strategies, illustrating its usefulness to advancing critical methods.

While more conventional health communication approaches have offered valuable research on health campaigns and behavior, many such studies could benefit from the holism of WPR. For example, research scrutinizing the rollout of at vaccine awareness campaigns and subsequent public response might seem to be examining how the problem of immunization has been, as the question prompts, "produced, disseminated and defended," but may not intervene at the root of the problem. One such example is Briones et al.'s (2012) study of vaccine coverage on YouTube, which traces positive and negative beliefs about the HPV vaccine. Conversely, if such a study were to begin from the perspective of problematization, as the WPR method encourages, studying HPV discourse would engage social and historical precursors to vaccine hesitancy. This is how the six questions work well together. Beginning from problematization (WPR Question 1) and attending to inherent presuppositions or assumptions (WPR Question 2), the research could engage dimensions like the "feminization of HPV" (Daley et al., 2017, p. 141), a virus which in reality is carried by people of any gender. Such an approach could then link the gendered nature of HPV vaccine discourse to concerns about the gendered nature of medicalization, or to the presupposition of risk with regard to female sexuality. This critical foundation, rooted in history and culture, engenders scholarly interventions with more progressive momentum. It gestures to the ways that health discourses can shape identity and reinforce normative understandings of illness.

CHC research is often invested in examining how beliefs about health, wellness, and medicine are produced and recirculated in diffuse discursive arenas including media and public debate. The sixth WPR question is the most closely akin to established techniques of interpretive and critical health communication research, which typically attends to the ways that "media representations produce and reproduce social knowledge" (Zoller and Kline, 2008, p. 101; Seale, 2003; Zoller and Dutta, 2009; Reitmanova et al., 2015). The value that Bacchi's particular phrasing offers for CHC researchers is in its function of linking the oppressive power of normative medicalization to its inherent potential for resistance.

With regard to the example of assisted dying discourse in Canada, the representation of vulnerable disability as the problem central to the issue of medical assistance in dying exposes how limited understanding of disability unproductively universalizes the disabled body. Social fears about vulnerability, that are due in large part to a culture of health that overvalues total autonomy and independence (Mitchell and Snyder, 1997; Ho, 2008; Kafer, 2013), where health is often understood as a matter of rigor or willpower (Lupton, 1995). This hegemonic conception of the body might be understood as causally linked to the ways that, as Harvey suggests, under neoliberal capital we define sickness as the inability to work (Harvey, 2000). The individualist view is in part an ideological by-product of a culture of health based on privatized care and a politics of deservingness that links good health care to hard work and full-time employment. Not only do people with disabilities face social barriers to living as they choose (Tremain, 2005; Schweik, 2009; Saxton, 2013; Zola, 2017), but by offloading social fears about vulnerability onto disability, medicalized assisted dying also ultimately further limits options for people living with disabilities as well.

CONCLUSION

Testing each of the six WPR questions for their relevance to doing health communication research reveals many productive overlaps with some critical approaches in the field. Furthermore, the consecutive breakdown of each critical consideration pushes the researcher to cast a broad net over the social, economic, and cultural forces at play in shaping discourses of health. Bacchi's research directly articulates how the method engages the critical interventions of Foucault and for better understanding how answers to each of the six questions are interconnected. It is particularly well-suited to disentangling complex problems—like the case of legalized MAiD—since it provides a roadmap for navigating the essential meaning-making practices at the heart of health care decision-making and of debates about living (or dying) well.

The WPR method of analysis breaks some of the most useful strategies for interrogating health discourse into a manageable step-by-step procedure. It asks the researcher to scrutinize the framing of problems and solutions, digging deeper into a key set of influences. It calls attention to deeper ideological forces that shape taken-for-granted assumptions about health. It gestures to the individuals, institutions and other powers involved in perpetuating such problems. It refocuses attention to marginalized people (as illustrated in disability views on MAiD) and perspectives (as in the cases of British abortion law). Attention to such views are generative for rethinking health discourse and governance, since they may be used to leverage for more equitable conditions. It demands for an intervention that acknowledges the effects of discourse on the lived material realities of the people affected. Finally, the WPR method pairs negative/oppressive practices of representation to their inherent potential for resistance and political intervention. This productive pairing is conducive to moving beyond interpretation and toward, for example, articulating resistance, or proposing alternatives to the status quo.

Bacchi's focus on problematization helps expose how through its fixation on culpability, MAiD policy inadvertently foregrounds vulnerability over autonomy, further limiting an already fraught patient and caregiver dynamic. I have explored how this is linked to an individualist notion of health; a concept well established by CHC research in other stages of life. The method unearths some of the historic and culturally specific aspects of Canada, including how fears of abuse have precipitated such beliefs. By attending to what is left unspoken in the discourse, the WPR approach zeros in on the ways that shared beliefs about disability say more about the anxieties of the able, than they reflect the realities of people with disabilities, or others at the end of life. With the call to explore the material and lived effects of representation, the method points out how despite being conceived as promoting autonomy, the law in question upholds ableist conceptions of good living. Finally, helping to link the discourse of vulnerability to a culture of health that overvalues total autonomy and independence, the WPR method helps to situate the problem at hand within broader debates in the field and points to possibilities for critical resistance, and progressive policy revisions.

DATA AVAILABILITY STATEMENT

The raw data supporting the conclusions of this manuscript will be made available by the authors, without undue reservation, to any qualified researcher.

AUTHOR CONTRIBUTIONS

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

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Health Communication and Citizenship Among Sex Workers in Mysore, India: Beyond “Centers” and “Margins”

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In the last couple of decades, there has been a significant turn toward critical and “culture-centered” approaches to health communication. Through the lens of critical ethnography, this paper aims to unsettle dominant Eurocentric and exclusionary notions of citizenship tied to a legislative and juridical framework of rights—as entitlements and obligations emanating from the “nation-state.” Instead, by focusing on the communicative practices of members of *Ashodaya Samithi*, a sex worker collective responding to local forms of discrimination and violence and susceptibility to the HIV infection, we disrupt dichotomous notions of political “centers” and “margins” by emphasizing how local forms of resistance and transnational alliance building constitute complex socialities that enable sex workers to navigate risks, demand services, expand their rights and freedoms, while fulfilling individual and collective responsibilities. We argue that, in the “developing” world, emergent forms of citizenship are more likely to be found not in some concentrated center of cultural authority like the nation-state, or its ancillaries, but in more dispersed sites where postcolonial struggles may appear as uncivil, coarse, insurgent, impure, ambiguous, marginal, and thus threatening to more purified, populist portraits of nationhood redrawn by politicians and health officials. This paper highlights alternative voices often blocked by the dominant discourse, thereby potentially recentering health communication in marginalized spaces. By juxtaposing field data and theory, this paper also aims to demonstrate how to engage in critical health communication research with rigor and quality.

Keywords: critical health communication, citizenship, sex workers, India, HIV/AIDS

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INTRODUCTION

The 1990s saw the rise of citizenship studies in the social sciences—a focus that primarily sought to contest traditional notions of citizenship. A plethora of social scientific literature, paralleling the advent of post-modernization and globalization studies, emerged to challenge narrow conceptualizations of citizenship as a “natural” legal status bestowed upon the rights-bearing individual living within a nation-state (Alexander, 1994; Isin and Turner, 2002). Critical scholars have argued, instead, for a broader understanding of citizenship that encompasses the complex social processes through which individuals and groups struggle for a variety of political and social recognitions, be they related to sexual, gender, racial, or ethnic identity or difference (Alexander, 1994; Isin and Turner, 2002; Isin, 2012). Notions of "modern citizenship," as linked with the nation-state and legal status, have been heavily criticized for the hypocrisy of giving the impression of "universalism" and "inclusion" while systematically excluding certain groups deemed as "outsiders" or undeserving of fuller sociopolitical recognition (Isin and Turner, 2002, p. 6). The emergence of citizenship studies, thus, has not only attempted to make visible the injustices and inequities that transpire in democratic states through processes of exclusion and marginalization but has also aimed to more fully recognize and support individual and collective efforts to reassert claims to social and political rights in the face of ongoing oppression.

Over the last couple of decades, critical theorists have worked diligently to rewrite the boundaries of citizenship beyond the confines of nationality, redrawing them to expose its underlying Eurocentrism and continuity with (neo) colonial imposition (Isin, 2012; Sabsay, 2012). Postcolonial scholars have been especially attentive to the exclusionary practices of governments in "developing" countries that have (ironically) taken up normative Eurocentric notions of citizenship in ways that reinforce grave injustices, while, at the same time, these scholars also stress the vibrant actions taken by social groups to confront and redress these injustices, claiming vital space in which to forge their social legitimacy. From this perspective, citizenship is reconceptualized in terms of political subjectivity rather than mere membership (Isin, 2012; Lorway, 2014).

The turn toward retheorizing citizenship has come with calls for increased participation of people in public matters that directly or indirectly affect their lives, thereby redefining a "good citizen" as one who "participates as a grassroots actor" rather than one who dutifully adheres to a social contract without question (Kligler-Vilenchik, 2017, p. 1889). For this reason, over the years, citizenship studies have been accompanied by an increased scholarly interest in community related concepts (such as community empowerment, social capital, and social cohesion) that speak to the ways in which people are conditioned and inhibited by their social and political context that has a direct impact on the quality of their lives (Labonte and Laverack, 2001; Dutta-Bergman, 2004a; Broom and Avanzino, 2010).

Communication studies scholars have long analyzed community dynamics, although the conceptual lens used for analysis, over time, has varied—ranging from transmission or instrumental to constitutive or interpretive perspectives (Broom and Avanzino, 2010). From the transmission perspective, communication is used as a tool by established (or identified) communities to meet their particular needs and goals, be it health literacy or early childhood programs, and in this sense, communication is seen as a means to an end (Broom and Avanzino, 2010). On the other hand, scholars employing constitutive perspectives examine how communication creates and sustains communities, and, in that sense, the constitutive elements of communication become an end in themselves (Labonte and Laverack, 2001). In this case, the focus is placed on the everyday communicative practices of people that constitute the very fabric of sociality, and the ways in which citizens negotiate matters of concern, develop a shared vision, generate innovative solutions to their shared problems, and in the process create interpretive communities (Burgess et al., 2006; Underwood and Frey, 2007; Broom and Avanzino, 2010; Kligler-Vilenchik, 2017).

Over the last decades, there has been a significant turn in health communication studies toward critical and "culture-centered" approaches that foreground participatory methodologies and dialogical processes as ways of engaging with local communities and "cultural voices" with the goal of confronting social structures that produce health and social inequities (Dutta-Bergman, 2004b; Dutta, 2007, 2010; Dutta and Basu, 2011). In the context of sex work particularly, drawing on their research among sex worker communities in Kolkata, India, Basu and Dutta have effectively demonstrated how participatory or community-led organizations that "emerge organically from within sex worker communities challenge commonly held notions" (of them being incapable or lacking agency), as well as unequal structures of power relations (such as those with clients, police, or health-care system) although also largely contained by them (Basu and Dutta, 2009, p. 87; also, see Basu and Dutta, 2008, 2011). With the help of Subaltern Studies and theorizing from below, Basu has further argued that sex worker's consciousness, as a marker of subaltern identity, is autonomous as it exists "parallel to and in spite of the mainstream discourse, resisting it and simultaneously adopting it to frame a local, seemingly fractured, version of rationality"—thus further exposing the universality claims of the "dominant health paradigm" (Basu, 2011, p. 392, 394). Basu also delineates multiple strategies that sex workers use (as forms of resistance) within sex work spaces, ranging from direct confrontation and deceit to risk management, negotiation, and appeasement (Basu, 2017). Such critical approaches emphasize the need for empowered communities with highly participative members who, as a result of increased participation, have greater perceived control over their everyday lives and have better access to healthful resources, thereby reflecting their commitment to the responsibility of being "healthy citizens" (Petersen and Lupton, 1996; Dutta-Bergman, 2004a).

While recognizing the power of engaged communities, scholars have nevertheless cautioned against shifting the discourse on citizenship too far with too great a focus on communities such that it would "localize global problems and obscure macro-level systems of power and decision making" (Labonte, 1990, p.158). Building on this argument, Zoller (2005) calls for "health activism" that empowers community members to challenge the status quo to bring about significant systemic changes, as otherwise there is a risk of community empowerment unwittingly playing into neoliberal regimes that reduce social and health services in the name of efficiency and thereby exacerbate existing health and social inequities, particularly among marginalized populations (Zoller, 2005).

Although "community" has been well-researched within communication studies and from various perspectives, with a few notable exceptions (such as Basu and Dutta, 2008, 2009, 2011; Basu, 2011, 2017), there still remains a significant gap in knowledge about communication pertaining to highly stigmatized and marginalized communities, particularly from a critical-interpretive stance. In this context, it is important to ask: how do multiple forms of hegemony play out in the everyday lives of people and how do communities challenge and resist dominant systems of power (Dutta-Bergman, 2004a; Zoller, 2005; Basu, 2011, 2017; Basu and Dutta, 2011; Dutta and Basu, 2011)? In other words, how are everyday communication practices implicated in the continual recreation of such political fields of domination and dissent? In more specific terms, we lack sufficient insight into the array of citizenship issues confronted by sexually dissident communities, particularly within contexts where citizenship is premised within frameworks of heteronormativity and heteromasculinity (Alexander, 1994; Atluri, 2012). Largely absent within the health communication literature are studies that point to where these political arenas of citizenship and sexuality overlap with post-coloniality.

This paper begins to fill this gap by examining the dominant Eurocentric and exclusionary notions of citizenship encountered by members of a sex worker organization in Karnataka (South India), known as *Ashodaya Samithi*—a collective which formed in collaboration with a consortium of global health actors to respond to localized forms of discrimination and violence and to reduce their susceptibility to HIV infection. Research has well-documented the structural challenges faced by female, male, and transgender sex workers and other sexual minorities in south India and, in particular, the "interlocking subsystems of discrimination and victimization" encountered by them in their everyday lives (Chakrapani et al., 2007, p. 358; Khan et al., 2018; Dutta et al., 2019). Our years of research in this area has shown how these sex workers face myriad forms of stigma, discrimination, and violence in different contexts, such as in accessing health-care services or encounters with the police or in their interaction with clients, brokers, boy friends, family, and the broader community (Argento et al., 2011; Reza-Paul et al., 2012, Thompson et al., 2013; Chevrier et al., 2016; Khan et al., 2018; Dutta et al., 2019). Overtime, in recognition of the commonness of their experiences and challenges, these sex workers in Mysore formed their own collective in an attempt to resist everyday discrimination and violence in their lives while also bonding to more actively participate in society (Argento et al., 2011; Reza-Paul et al., 2012).

In this paper, by focusing on the communicative practices of members of *Ashodaya Samithi*, as reflected in their narratives of lived experiences, we disrupt dichotomous notions of political "centers" and "margins" by emphasizing how local forms of resistance and transnational alliance building constitute complex socialities that enable sex workers to navigate risks, demand services, expand their rights and freedoms, while fulfilling individual and collective responsibilities. We argue that, in the "developing" world, emergent forms of citizenship are more likely to be found not in some concentrated center of cultural authority like the nation-state, or its ancillaries, but in more dispersed sites where postcolonial struggles may appear as uncivil, coarse, insurgent, impure, ambiguous, marginal, and thus threatening to more purified, populist portraits of nationhood redrawn by politicians and health officials.

METHODOLOGY

Since 2004, as an alternative to the top–down, behavior-centered targeted health intervention model, a group of health researchers from the University of Manitoba, under the auspices of *Avahan* (a Bill and Melinda Gates Foundation HIV/AIDS initiative in India), worked on creating the conditions for the emergence of a community-led sex worker collective in the Mysore and Mandya Districts of Karnataka, South India. The primary goal of the initiative was to reduce the risk of HIV and sexually transmitted infections (STI) among female, male, and transgender sex workers, through community mobilization, capacity building, better access to health services, and a curriculum-based demonstrative learning in elements of community-led interventions, with the ultimate goal of having an organically developed community-based organization. From the initial years, the program reported high level of success in reducing the risk of HIV/STI and in capacity building, resulting in the emergence of an increasingly assertive community-based organization, the *Ashodaya Samithi*. Over the years, the organization's goals and management have changed with increased participation of members in setting the agenda that resulted in a shared vision and path of action for the collective that often spanned beyond the locale.

The current study was conceived to probe the formation and growth of *Ashodaya Samithi*, to understand the conditions and processes that are involved in the emergence of a highly participative sex worker collective, and to foreground the experiences and aspirations of the members in their own words. To this end, we employed a critical ethnographic approach that involves reflective thinking, empirical inquiry, and transformative action. The foundational premise of critical ethnography is the act of critique that is "iterative, moving back and forth between examining the assumptions and foundations of how things are, how they got that way, how things might be changed, and why we should care in the first place" (Thomas, 2003, p. 46). In the process, critical ethnographic researchers attempt to locate meanings within the broader context of unequal power structure, unmask hegemony, and challenge the oppressive forces rather than merely affirm the status quo (Crotty, 1998; Thomas, 2003). These core themes of critical ethnography, particularly where it demands the foregrounding of the world view of the subalterns or the marginalized, made it a suitable methodology for our study in which we wanted to situate the experiences and actions of the sex workers within the broader context of systemic inequities faced by them. Accordingly, the study adopted critical ethnographic methods that included (a) 4 months of observation at multiple intervention sites in the districts of Mysore and Mandya (e.g., solicitation sites, learning centers, drop-in centers, clinics, organizational meetings, and group activities of the *Ashodaya Samithi*); (b) semistructured interviews ($n = 50$) with researchers and professionals who initiated the project, service providers (e.g., managers, outreach workers, counselors), and sex worker members of *Ashodaya Samithi*; and (c) a document analysis of project proposals, progress reports, HIV/STI and behavioral surveillance data, learning and counseling materials, news reports, etc.

The ongoing close partnership between the University of Manitoba and *Ashodaya Samithi*, under the umbrella of *Avahan* program in Karnataka state between 2003 and 2010, provided the primary point of entry for the study. The first author introduced the study to key members of *Ashodaya Samithi* and its advisory board and, through a series of meetings, garnered their interest and help in shaping and conduct of the study. After initial consultations, an interview guide was developed with input from the community to make the questions most relevant to their needs and experiences. The first author then trained a few interested community members in core issues of qualitative research and conduct of interviews. This community-based research is part of the methodology adopted by authors in their other studies conducted in the region as it is most appropriate for marginalized communities, not simply to gain entry in the "field" but to place their insights and guidance on center stage at every step of the study to make the research process and findings most fruitful for the community and the researchers. In fact, the participation in the study as well as the training for research was much appreciated by the community, as articulated by this participant: "they [university researchers] conduct programs and bring the community people together which create awareness in issues and to call us to conduct interviews means recognition for us, which helps us grow."

In this collaborative spirit, the first author and the trained community researchers conducted interviews with sex worker members of *Ashodaya Samithi* including female sex workers ($N = 23$), male sex workers ($N = 11$), and transgender sex workers ($N = 6$). The interviews were mostly conducted at the *Ashodaya Samithi* office or its drop-in center, or at a mutually convenient place (such as local eateries, parks) and lasted 30–90 minutes. The topics discussed included the social and structural contexts of their lives, factors that led to the formation of the collective, the initial phases and growth of the organization, the benefits and impact (if any) felt in their lives and community, the need for such an organization, and their suggestions for improvements and broadening of goals. The study involving human participants was reviewed and approved by Simon Fraser University Research Ethics Board. Informed consent was explicitly obtained from each participant with the reiteration that participation was completely voluntary. Participants had a choice of providing written or verbal consent, with most of them opting verbal consent, which was not surprising given the largely oral nature of Indian society, the history of persecutions against sexual minorities in India, and that most participants lacked formal education and did not know how to read and write. All consent procedures followed were approved by the Ethics Committee that approved the study. Participants were also given a choice of getting the interview conducted by the community researchers in their local language (Kannada) or by the first author in English or Hindi. With their expressed consent, the interviews were audiotaped and transcribed (and translated) in English. Qualitative content analysis was conducted to identify substantive themes emerging from the interview dataset, and a coding scheme was developed through an iterative process, in which transcripts were read and reread by the authors to generate a list of emergent codes that was further refined. Interview data were managed with the aid of NVivo 11 software.

While the broader study included observations and interviews with a variety of key players associated with *Avahan* initiative and *Ashodaya Samithi*—providing an understanding of the context and background—for the purpose of this paper, we focus on interview data that reflects the experiences of *Ashodaya Samithi* sex workers ($N = 40$) in running a community organization, emphasizing their vision for their collective.

FINDINGS

The age of participants ranged from 21 to 46 years with an average of 33 years. Most had no formal education (54%), and the rest had some primary schooling (18%) or finished high school (22%) and two (6%) had a higher degree. Furthermore, most (87%) female sex workers were married with children while this was not the case for male and transgender sex workers. Most interviewees conveyed genuine interest, enthusiasm, and passion for *Ashodaya Samithi* and a vision for the future as a sex worker's collective. In this paper, we foreground themes that particularly showcase the communicative practices of participants through which they assert their citizenship locally, nationally, and even on an international level.

Collective Identity and a Sense of Pride

A key theme running across participants' narratives was the growing feeling of a common identity, a sense of purpose in life and pride in their work. Many participants commented that their shared focus on the health issue of HIV fostered their coming together to realize the commonalities of their life situations and their strength in numbers.

> *Ashodaya Samithi' s main intention is to provide guidance to the community members in a right way and also teach us to resolve the problems that the sex workers face in their life, and very importantly tell us about our health issues, what is HIV, how can we prevent HIV by using condoms, all these things we have learnt from Ashodaya Samithi... Our life is not simply dedicated to sex work, we also have life in future, and if we have to come forward in the society, what are the important and good things that we should be doing is also what I have learnt after coming to Ashodaya Samithi. (Female sex worker, ID #10)*

> *Many Samithis [organizations] are working towards preventing HIV in Mysore, but... they[only] give condoms... in Ashodaya they conduct every program like HIV prevention, STI prevention, distribute condoms, referring from our[Ashodaya] clinic to other hospitals and also identify wherever there are other HIV patients and provide them with medicines, so Ashodaya Samithi is doing all this [for us].... (Female sex worker, ID # 13)*

Given the historical exclusions that sex workers have faced within the government health system, *Ashodaya Samithi*, by facilitating access to health care and assuming responsibility for sex workers' health and well-being, has made available structural resources necessary for good health and, in that sense, has opened avenues for them to belong more fully in society. By providing health services, *Ashodaya Samithi* has allowed its members to reimagine a sense of belonging in society, an imagining that opens up new life possibilities in the future beyond despair and oppression. Health consciousness has a critical role to play in community participation as healthy individuals tend to be more engaged in their community, provide support to each other, cultivate the capacity to have their voices heard, and situate themselves in a better position to challenge and transform structural forces that impede their health (Dutta-Bergman, 2004a).

Besides a focus on health issues, *Ashodaya Samithi* has also worked toward making sex workers aware of their social entitlements and legal rights. Being more literate in rights and entitlements in many ways transforms how people accept their positioning in society and their willingness to fight against injustice.

> *Earlier we did not know anything about IPC 377 [gay criminalisation]… We thought that the rights were only for the males and females in society but now we know we also have rights. We now know about HIV and though we are transgender, we are also human beings and we are part of the mainstream. [Earlier] life was only begging and sex work, but now after forming the Samithi, our attitudes have changed and we can now look into a broader spectrum.… I have now taken my ration card, PAN card and I know about my rights after coming here. I have also learnt about my property rights and I have the courage to live happily and help others in society. (Transgender sex worker, ID # 1)*

Historically, within the context of Indian caste system, sex workers and other marginalized groups accepted their low positioning in society and remained on the periphery without much questioning. Although, over time, many social entitlement schemes have been made available for disenfranchised people in India, they have made limited impact. Rather, it is the highly participative sex workers collectives, like *Ashodaya Samithi*, that have had success in disrupting the traditional notion of linking marginal status with fate (and thus questioning passive acceptance of marginality). In fact, *Ashodaya Samithi's* efforts have sparked critical consciousness among its members and the idea that they can transform their socioeconomic destinies. It has opened up the possibility for them of becoming a member of society, of being raised out of the shadows of marginality, in a way that the state and social welfare has failed to accomplish.

Such feelings of collective political existence and of optimism to bring about a change amid otherwise constraining structural conditions through collective efforts mirrored in the narratives of many participants.

> *We realized we cannot face all of them all alone, and if we have a Samithi[collective] of our own, we can face anything. When thousands of us make a noise together, our problems will be heard. Hence, we decided to form our own Samithi. MSMs [men who have sex with men] will have many problems at home, TG [transgender]will not be allowed to stay at home, they say you should have remained as a boy and forcefully get those married and FSW girls [female sex workers] are thrown out of the house once they came to the profession—knowingly or forcibly. (Transgender sex worker, ID# 1)*

> *Before Ashodaya's existence, we had problems from miscreants, police and others [shopkeepers and people in neighbourhood], we couldn't avoid it. After forming the Samithi, [even] boyfriends get scared a little thinking what will happen if we complain to Ashodaya. When we looked at police [earlier], we would get scared and run away, thinking police will come and take us away. But now police also give us respect, they also have a fear that we have an association… that's why we sex workers can walk around without fear, after forming Ashodaya Samithi. (Female sex worker, ID # 13)*

Ashodaya Samithi here not only can be seen to play a protective role for its members but also, as a collective, it enables its members jointly to enter into a kind of social contract with power authorities (local, state, or central government) and local entities (such as lodge owners, police officials, hospitals) where they can (and do) receive recognition as a legitimate group because of assuming particular responsibilities (i.e., health service delivery) conventionally under the jurisdiction of the state. In this case, *Ashodaya Samithi* members are not just championing for human rights in defiance of the state, but they are taking up responsibilities like the state, which is at the limits of its reach and efficacy. Moreover, this is not a small or marginal work that they engage in; rather, it has become quite central to the work of fighting the HIV epidemic in the country. Indeed, programs throughout India hinge on the participation of these types of collectives, and *Ashodaya Samithi*, through such endeavors, disrupts notions of margins and centers in the context of the nation state. Such health activism on the part of sex workers helps build up not only their self-esteem and their sense of collective responsibility but also a pride in their profession and consequent demand for status in society.

> *…in Mysore nobody would come forward and say that they were sex workers, because we had a deep fear that if we say that we are sex workers then they might think that we might be HIV positive, or society will treat us badly, or people at home might throw us out of the house.…but after forming our Samithi, we learnt that there are thousands of people like us and why should we not identify [with our] profession… if I identify my profession, society also identifies me and if I don't identify myself, nobody would identify me. (Male sex worker, ID # 10)*

> *[Earlier] if someone threatened, we would get scared and go away from there but after Ashodaya came into existence, we learnt that ours is also a job and we are ready to reveal the information anywhere that we are sex workers and we are also ready to face any kind of problems… All the shop owners say that this is our shop; similarly it's our body and we give pleasure to others and don't hurt anybody. (Female sex worker, ID #11)*

The above narratives convey strong emotions about "becoming an *Ashodaya* sex worker" as being highly affective and politically productive for this group, especially in how it rewrites their individual life experiences as part of a larger form of collective oppression facing "a people." It indeed sows the seeds of defiance and rebellion while igniting a hunger for social change that spills out beyond the confines of public health projects—more than merely instrumentalizing "the community" to meet the ends of global health goals (such as the end of HIV epidemic). In forming a sex workers community, *Ashodaya Samithi* creates forms of visibility and raises collective awareness which, in turn, empowers members to assert their right to seek and receive bodily pleasure, framing them in terms of a citizen's right to work and earn a livelihood in the society.

Struggle for Social and Political Recognition: Beyond Local

Over time, collective consciousness begins to supersede the influence of the nation state in ways that open up new political terrain, permitting *Ashodaya Samithi* members to feel affirmed and capable of challenging and making demands on the state, thereby asserting their social and political legitimacy, as reflected in the thinking of participants.

> *Wherever there are sex working girls like us in the society, we should be exemplary to all of them and we are not only these many sex workers in Ashodaya, there are many sex workers in many different countries, different Taluks [sub-districts] and they should take care of their health. In some places, they would not know anything about health, so the main intention is to reach the place wherever our sex workers are (Female sex worker, ID# 15)*

> *Many people from Ashodaya have gone to Rajasthan [Indian state] and are working there, all these programs are conducted there also and recently we got the news that it has been very successful… our community people whichever corner they are in, whichever, state, country, international, our Ashodaya should be an exemplar. How we have achieved our goal in Ashodaya, they [other sex workers] should also achieve their goal… our community should not have an end but community people should get rid of HIV is the only thing that I want to say….. (Male Sex worker, ID # 5)*

The above narratives speak to the growing political awareness among members of *Ashodaya Samithi* that comes from their increased consciousness of their collective identity and the need to mobilize to forge the legitimacy and recognition of their identity as an oppressed group, to assert their rights and to fulfill their obligations as members in national and transnational sex work alliances. This growing sense of collective identity and global awareness has been cultivated by *Ashodaya Samithi* through a number of their endeavors, be it participation in national and international HIV/sexual health conferences or partnering with research institutions and universities or through their active representation on the boards of national sex work activist networks. It is through such intense engagement with these programs that the sense of obligation of their members have come to stretch across national boundaries, even as they assert themselves in their own localities.

Within the local context, the members began by asserting their rights to engage in activities that they had traditionally been excluded from such as participating in annual Indian Independence day celebrations and other cultural events that enhanced their sense of pride and belonging in society. These were "privileges" that had been denied to them historically through systemic processes of exclusion, often seen by them as not having the "freedom."

> *[Earlier] when the flag was hoisted during Independence, we would watch it secretly. We did not have freedom then. But after Ashodaya, we are hoisting our own flag. (Female sex worker, ID # 23)*

> *Earlier if someone conducted rally… we would think… why shouldn't we do it and again within us we [knew] we couldn't do it but we wanted to come forward and start celebrating Independence day, Republic day and all functions, as the other workers do, as we want to identify ourselves as sex workers… [now] we invite all taluk members, organize functions and would go for rallies as all other workers. We conduct "May Day" [International workers day] with an intention to bring Ashodaya in the first [forefront]… we want recognition. (Female sex worker, ID #3)*

Besides gaining a strong political orientation, the members have also worked toward cultural recognition for their community by organizing cultural activities and local festivals at *Ashodaya Samithi*.

> *… being an MSM, I left home 3 years ago, I don't go home for any of my home programs, any festivals or cultural activities… many people in the community have also left home… [now we] do cultural activities at Ashodaya and follow all the cultural traditions… when we do all this, the society people should agree with us because like a common man, we celebrate festivals, we are in good financial condition, and also maintained relationship with neighbours and people around us. So everyone must accept us and hence Ashodaya's name will definitely grow. (Male Sex worker, ID # 32)*

> *After forming our Samithi, we are conducting all programs happening in the society… we celebrate Independence Day, we celebrate festivals… to be honest, if we are at home during festivals, we are not [able to] celebrate the festival… I would think that if I was in Ashodaya, we all could have been together, I could celebrate this festival with everyone. (Male Sex worker, ID # 10)*

Cultural festivals here can be interpreted as celebrations of "authenticity" tied explicitly and implicitly to portraits of nationalism or regionalism, and in this sense, engagement in cultural performances at *Ashodaya Samithi* can be seen as pageantry of nationalism or localisms. *Ashodaya* has thus successfully created places of belonging for sex workers who have been otherwise profoundly excluded in society. Participation in these events can be seen to constitute powerful modes of citizen engagement as they become sites of collective activity or "cultural citizenship" that involves bonding, community building, and everyday communicative practices of identity construction (Burgess et al., 2006). Thus, it is through these symbolic processes or forms of participatory culture that identity consciousness flourishes, leading to individual and collective activism that further empowers members to assert their rights and fulfill their obligations.

Beyond Responsible Citizenship

A sense of common identity, belongingness, and bonding thus emerged through high levels of participation in community activities which also led to feelings of personal and collective responsibility among *Ashodaya* members and the willingness to undertake responsible actions. To a large extent, their responsible actions began primarily in their personal lives on an individual basis—be it in controlling their addiction to alcohol, focusing on personal hygiene whereby they are able to enhance their value in the eyes of their clients and society or their refusal to have sex without condoms. Even though these actions may have been undertaken individually, the impetus for it came through a collective sense of responsibility where each member supported each other in dealing with their daily realities and to take responsible actions.

> *A lot of changes have taken place. Before we would sit anywhere, sleep anywhere. No one would want us for even Rs. 50. Now after Ashodaya, we come here, have a bath, soap and shampoo is available, wash and dry our clothes, get dressed neatly, and go… now they will take us even for Rs 250….Earlier we used to stand on the roads, booze, fight with others and go for sex if we are offered Rs. 500 without condoms. Now… we have changed. Without condoms we do not do sex. We tell them, we will come for sex only if there is a condom. (Female sex worker, ID # 22)*

> *Normally sex workers are prone to bad habits…I would drink a lot earlier… and would never save or keep the money that we earn… But [now] when we have our own co-operative society, if we earn Rs. 1000, we think of saving or depositing Rs. 500 for my two children. So, we were very happy when we started a co-operative society of our own. Our children, the children of sex workers are taken care by our Ashodaya Samithi, as they are sent to hostels and in various fields… so after forming the Samithi, we have come forward saying that we have strength and determination in us. (Female sex worker, ID #11)*

> *[Earlier} my intention was not to see anyone but just go straight, like how they put a mask to the horse, I had such feeling, anyone falls, has a fight or does anything, I [we] would never look at it. If someone is fighting and call us, we would just take our client and go to the lodge as we wanted money… but now, we have a feeling to help people, now when we see someone fighting, though we are talking to our clients, we will leave that and go help… we have changed to this extent. (Female sex worker, ID # 14)*

The above narratives can be interpreted as speaking to the notion of responsibilization, as discussed in the literature on neoliberalism, citizenship, and governmentality, where the voluntary sectors work on producing responsible citizens (rather than social-justice advocates) in alignment with the goals of the state (Ilcan and Basok, 2004). However, at the same time, we could argue to go beyond a governmentality perspective, by looking at how the forms of responsibility they assume do not merely feed into alignment with governmental objectives but rather feeds into projects and approaches that are aimed to subvert and re-write the boundaries of citizenship, of "being" in Indian society—in ways that counters and subverts the normative project of the nation state. Although the responsible choices they made may seem to meet the social welfare goals of the state (like HIV prevention, or poverty alleviation), the propelling force for these changes is one of growing collective consciousness that empowers these sex workers to challenge those in power (police, health, and electorate system), to claim social and political recognition, and to gain full citizenship rights instead of only being in the role of a dutiful citizen. In fact, their sense of responsibility and engagement extended beyond immediate individual needs to the broader community realm and even public sphere including policy fronts to include issues that would have impact on their health, profession, and on future generations, as is evident from narratives below:

> *To tell you culturally, we provide more importance to boys, girls and hijras [transgender] of age group 18–25. We have formed a Youth Wing and in this we conduct cultural programs, show our performances in different places… we do all this and the funds we get from there we keep half of it and rest half we give it to Ashodaya because in future it will be helpful for HIV positive members.* (*Male sex worker, ID # 6*)

> *Earlier, we did not know anything about our health. Now we know. We formed groups and decided what must be done and teach good things to others and work like other committee members. We decided that girls who are [less than] 18 years should not do sex work, should be sent to school or stitching, dance classes or embroidery. We tell them please do not do sex work or call your parents and go back to your parents. (Female sex worker, ID #18)*

Although *Ashodaya Samithi* articulates and politicizes sex work as a form of labor and organizes itself as a labor collective (employing the words of collectivization and mobilization as used in trade unions), its narratives articulate a sense of obligation to members in intimate familial and parental terms, thereby conveying care for the next generation. In other words, the texture of solidarity within *Ashodaya* takes on the inflections of kinship. These narratives also speak to the anti-trafficking work undertaken by *Ashodaya Samithi* and their political acumen with respect to the powerful global anti-trafficking lobbies that tend to cast all sex work as exploitative. By setting up an anti-traffic committee, for underaged girls and boys to get them out of sex work, *Ashodaya Samithi* enacts a political strategy that makes a clear distinction between sex work as a consensual form of labor in contrast to forms of exploitation that characterize other women's and children experiences. In this sense, the committee aims to work toward both "rescuing" underaged and exploited people and, at the same time, carve out a space for legitimate sex workers (Jana et al., 2013).

DISCUSSION AND CONCLUSION

The past decade has seen a particular focus on critical and culture-centered approaches to health communication (Dutta, 2010; Dutta and Basu, 2011; Khan, 2014), and yet the idea of citizenship, especially in the context of HIV/AIDS and Global South, remains largely unattended and undertheorized. In this paper, based on the findings from a larger ethnographic study on the formation of a sex workers collective in South India, we situate collectivization and community-led structural intervention among sex workers as an emerging form of citizenship, which, we argue, is fundamentally different from traditional understanding of citizenship centered on nation-states and from which these communities have been historically excluded.

In interviewing and observing the sex workers in the study, we found them focused on the structural issues in their lives, particularly their experiences of violence and stigma associated with their work, which is directly linked with HIV and other health problems encountered by them. The urgency to form a sex worker's collective thus arose from their growing awareness of their collective experiences of systemic inequities and injustices, both social and health, and the need to mobilize to claim social and political recognition as sex workers in society. As reflected in the narratives of participants, the umbrella of *Ashodaya Samithi* provided them with forms of protection, visibility and political space from which they gained the strength to assert their identity, challenge the power structures, assume obligations as responsible citizens, and demand structural resources from the state for the same. Through global health frames of reference (such as HIV prevention), new forms of belonging and politics were created that produced a kind of reflexivity among sex workers in which they came to question more broadly the oppressive position in which they have been placed in society. This is particularly evident in instances where the study participants claimed their right to celebrate India's Independence Day or cultural festivals, their insistence on safe sex and engagement in financial planning for themselves and their children, among many other actions undertaken. These seemingly mundane activities when closely investigated, as urged by critical ethnography, expose the existing asymmetrical power relations and social inequalities in society and foreground the communicative practices adopted by sex workers that enable them to assert their citizenship even from the margins of society. Through collective health consciousness and mobilization around HIV prevention, this otherwise disenfranchised group of sex workers have thus begun to transform themselves into a responsibilized political force that is able to assert its own unified politics (as a definable social group with a unified identity) and legitimate social positioning. Being seen as a politically viable entity and with defined purposes (be it health or social) provided them with power and confidence to challenge and change myriad forms of social oppression encountered—and in that sense, they can be seen to take the step beyond health citizenship and toward health activism (Zoller, 2005).

Besides providing a political orientation and space, *Ashodaya Samithi* could also be seen to function like a kind of social welfare organization for its members that filled a tremendous gap on the part of the state in terms of serving the health and social service needs of sexual minorities. At the same time, this space existed as a protected enclave that temporarily insulated sex workers from the daily grind of oppression that persists outside the doors of *Ashodaya Samithi*, as noted by participants when they talked about "being themselves" and able to wear clothes of their choice in *Ashodaya Samithi's* office space. The provision of this personal and cultural space, in certain ways, enhanced both their recognition of the myriad individual and collective oppressions they face in everyday life, and at the same time, it offered a temporary respite from the crushing social conditions of discrimination and structural violence. This respite in many ways allowed them to collectively gather their strength, articulate solutions (social or political) to their problems, and choose specific tactics and forms of organizing to bring about a specific change or at least make an attempt to do so (Zoller, 2005).

In this paper, we have sought to problematize the conventional understanding of citizenship that has still remained centered on nation-states in the developing world. Instead, we argue that citizenship needs to be explored in spaces and actions that have so far remained outside the margins of the state such as in the everyday creative (and resistive) communicative practices of marginalized communities. In doing so, we are mindful of the dialectical tensions in the relationship between "structure" and "agency" since even when sex workers assert their identity, rights, and freedom, they often do so through narratives and communicative acts that seem to correspond with traditional notions of citizenship (such as through participation in India's Independence Day celebrations). However, as Basu and Dutta also suggest, subaltern consciousness, while relatively autonomous, exists in relationship to, or as reflection of, one's conditions of marginality (Basu, 2011, 2017; Basu and Dutta, 2011). Second, it is often through these acts of "cooperation" or "participation" in the mainstream practices, such as Independence Day or Republic Day celebrations or other cultural festivals, that these highly stigmatized and marginalized communities necessarily end up rescripting their own narratives—narratives that rewrite the boundaries of citizenship in ways that subverts the dominant, universalist, and normative project of the nation-state.

Thus, critical and cultural approaches to health communication have a key role to play in unraveling the myriad ways in which citizenship gets mediated in the everyday lived experiences of people and foreground the agency of traditionally marginalized communities in resisting and changing dominant power structures (Zoller, 2005; Dutta, 2007, 2010; Dutta and Basu, 2011; Khan, 2014; Khan et al., 2018). To that extent, our study engaged with sex workers right from the start, beginning with community consultations to refine the study aims, followed by their concrete input in the development of interview guides and training and participation of peers in conduct of the interviews. As noted earlier, this process of engagement, besides grounding the study in the local realities, provided opportunities for reflexivity on the part of all participants, especially with the interview questions serving as catalysts for mutual dialogue. Moreover, in our analysis of data, we foregrounded the voices and experiences of the community members and took lead from there to understand the exclusionary and discriminatory practices faced by them, as well as myriad forms of local and global resistance and alliance building in which they engaged in. As found in our study and noted by de Souza (2011), the daily struggles of marginalized sex workers in India is not simply to acquire structural resources needed to lead fulfilled lives (although significant in itself) but "to be productive and contributing members of society. It is not a fight *against* society, but rather…it is a fight to be a part of society or to be allowed to be good citizens within society" (p. 34).

DATA AVAILABILITY STATEMENT

The datasets generated for this study are available on request to the corresponding author.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by Simon Fraser University Research Ethics Board. Written informed consent for participation was not required for this study in accordance with the national legislation and the institutional requirements.

AUTHOR CONTRIBUTIONS

All authors contributed to the conceptualization and design of the study. SK and RL led the development and writing of this manuscript. JO'N, AP, and SR-P contributed to the data analysis, revising, and finalizing of the manuscript.

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Working the Hyphen From Below: The "Thick Decryption of Subtext" and the Micro-Politics of Knowledge Production

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Engaging in reflexive analysis or "working the Self-Other hyphen" is central to establishing the credibility and trustworthiness of critical qualitative research today. However, while there is a robust literature on how to navigate the Self-Other hyphen, this tends to be written for white scholars going into communities of color. There is very little written by and for scholars of color going into the field to study whiteness. In this paper, I unravel the challenges and complexities of negotiating the Self-Other hyphen as a scholar of color. This manuscript is based solely on a secondary analysis of previously published data. I draw on examples from my own communication research over the past decade in two different settings: HIV and AIDS in India and hunger and food insecurity in the United States. I use peer reviews and reactions from dominant actors in the academy to elucidate how orientalist and white racial frames impact the interpretive, analytical, and writing work of qualitative research. Highlighting the micro-politics of knowledge production, the paper argues that since power operates differently for researchers of color in white spaces, considerations for working the hyphen must also be dramatically altered. The paper offers suggestions for how researchers might maintain a critical, counterhegemonic presence in their research in the face of hegemonic responses.

Keywords: qualitative methods (interviewing), reflexivity, race and class, whiteness and white fragility, social justice, validity

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> Interviewer: What do you mean like you heard stories?
> Xavier: No, it's, it's, okay, I'll tell you this. Okay, in 1979 I became a Muslim, so you know about that?
> Interviewer: About that?
> Xavier: Muslims.
> Interviewer: Yeah, I do
> Xavier: Okay
> Interviewer: I'm from India originally, so I grew up with a lot of Muslim friends and family.
> Xavier: Alright, okay. So, anyway *now I can feel a little comfortable* (emphasis added) because you know a lot of things I say, I say in Arabic, but anyway when I go to the Masjid there's a lot of doctors there, you know and…
>
> Xavier, African American male, Chum client[1]

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[1] Xavier was one of the ~70 interviewees who participated in the study on hunger and food insecurity now published in the book *Feeding the Other: Whiteness Privilege and Neoliberal Stigma in Food Pantries* (de Souza, 2019). Xavier was a frequent client of the Chum food pantry- one of the two food pantries studied in the research project.

INTRODUCTION

This opening excerpt depicts a brief exchange that took place between a research participant (Xavier) and myself (the interviewer) in a midsize city in Midwestern United States. I, an Indian immigrant, a woman of color, a researcher studying the stigma of hunger and food insecurity in food pantry spaces and my interviewee an African American Muslim man who experiences hunger and food insecurity, racial and religious stigma, and uses the Chum food pantry[2]. In this excerpt, what stood out to me was how cautiously Xavier disclosed his religious identity and then quickly followed it up with a gentle open ended question "you know about that?" At my response, our worlds joined. His face immediately relaxed, he leaned back in the chair, a big smile on his face, and began to talk. As I reflect on this research project spanning a number of years and a number of interactions with people from a variety of racial and class backgrounds, I realize that the moments of connection that I made with people of color were not coincidental. These moments of connection stemmed from my own standpoint, ethical orientation, and phenotypical markers all of which came together to create a safe space for people of color to talk about racism.

Interactions such as these have forced me to reckon with my standpoint as a researcher and how this is hypervisible in the field and in my writing. As a "middle-ground[3]" social researcher and a South Asian woman of color, my critical/feminist/racialized standpoint brings moments of connection, but also intense scrutiny. White social researchers are normalized in research settings, so have far more flexibility in how and even *if* they carry their voice, body, race, class, or gender into their work. Just the opposite is true for people of color. People of color do not escape scrutiny even when in positions of power as researchers. Our bodies do not disappear in the field or in our texts. Our ideological and political commitments are on full display in how we represent, analyze, interpret, and write about "the data." Indeed, the more clearly we write, the more we are on display. This makes it impossible to fold into the text unnoticed.

The Self-Other hyphen, a term coined by Fine (1994), refers to a longstanding concern in critical qualitative and ethnographic research about the need for reflexivity on the part of researchers, where reflexivity involves "thoughtful, conscious self-awareness" (Finlay, 2002, p. 532). The central idea here is that identity directly and indirectly influences the research process, so conscious self-awareness is required to understand this influence and increase the integrity, credibility, and trustworthiness of qualitative research. Over the last century, qualitative research has been deeply implicated in colonial, racial, and nationalist projects with the relationship between researcher and the "researched" often mirroring the relationship between oppressors and oppressed. Reflexivity is seen as a way to intervene upon the colonial and neocolonial gaze.

In terms of ability, sexuality, and class, I am on the upper rungs of the hierarchy, but in terms of racial, gender, national and political categories I am nearer the bottom. As a middle class woman of color, a researcher, a Third World woman, and a recent immigrant to the United States marked by color and phenotypical difference, conducting ethnographic research in a predominantly white city in the Midwest and then having it move through a historically white academy, has provided immense opportunity for reflection on the Self-Other hyphen. I started out my academic career studying people living with HIV and AIDS in India and afterwards embarked on a new trajectory of research studying hunger in the United States. While my work has always been reflexive in terms of historical, cultural, and systems thinking, my most recent work on hunger and food insecurity has allowed me to probe a more racially-sensitive reflexivity. This research now published in the book *Feeding the Other: Whiteness, Privilege and Neoliberal Stigma in Food Pantries* (de Souza, 2019) was interested in food systems and food structures as well as the interactional dynamics of race, class, and gender within food pantries[4]. As the work moved through academic circles, I noticed stark differences in how people received it. It received validation from people of color—participants and non-participants—who saw their truths represented in the work and pulled me aside excitedly to say "yes! I've been wanting to talk about that." Many claims were also validated by white people who for the first time saw verbalized that which was most uncomfortable to them about doling out cheap food. A strenuous challenge however came from whites within academia who took positions of defensiveness and challenged my assertions. These were peer reviewers, students, and other institutional actors who said "But, what about…?" and "But, you didn't…" or just simply said "But, I disagree."

As I attempted to move counterhegemonic assertions through white-dominated academia I experienced subtle forms of suppression that mirrored my social location. Beyond the anticipated labor of making justified arguments through research design, data collection, analysis, and writing, there was a meta-level of labor that had to do with negotiating ideologically-motivated standpoints, emotions, and pushback from dominant

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[2] Chum and Ruby's Pantry were the two food pantries studied as part of the research project on hunger and food insecurity now published in the book Feeding the Other: Whiteness, Privilege, and Neoliberal Stigma in Food Pantries (de Souza, 2019).

[3] I borrow Laura Ellingson's (2009) conceptual framework for qualitative methodology to identify my own proclivities as a qualitative researcher. Ellingson maps the qualitative continuum from a realist/positivist social science stance on the far right, to social constructionist middle ground approaches in the middle, to the artistic interpretive paradigm on the far left. Middle ground approaches involve traditional qualitative/ethnographic research methods (e.g., focus groups, observations, case studies, etc.) and tend to use first person voice, narratives, and interview snippets in the writing and representation of data. Middle ground researchers tend to be interested in situated knowledge, description and understanding, troubling taken-for-granted assumptions, and generating pragmatic implications (see Ellingson, 2009, p. 8–9).

[4] In *Feeding the Other* (de Souza, 2019) I argue that food pantries stigmatize their clients through a discourse that emphasizes hard work, self-help, and economic productivity rather than food justice and equity- a phenomenon I term "neoliberal stigma". I argue that these "framing, blaming, and shaming" discourses reframe the structural issue of hunger as a problem for the individual hungry person. The book documents the voices, experiences, and realities of people living with hunger; the failure of public institutions to protect citizens from poverty and hunger; the "whiteness" of food pantry volunteers caught between neoliberal and social justice concerns; the culture of suspicion in food pantry spaces; and the constraints on individual food choices.

groups. I was also left in a quandary about how to approach the question of credibility in qualitative research. There were many moments when I second-guessed and doubted my claims, claims that were grounded in the lived experiences and voices of participants at the bottom of the economic and racial hierarchy, but that were contested by dominant actors. There were also times when my thick descriptions of people and perspectives, much to my horror, reinforced hegemonic interpretations among dominant groups. I realized that the standard metrics for establishing credibility had shifted beneath me; the techniques that I had learned within whitened spaces of academia no longer held water.

THE GOAL OF THIS PAPER

While there are several unwieldy dimensions to the Self-Other phenomenon, in this paper, I put a fine point on one particular aspect, namely how the Self-Other hyphen is negotiated in the interpretive, analytical, *and* writing work of qualitative research "from below." I use the phrase "from below" to refer to research that makes a preferential option for disenfranchised people from a social justice perspective and seeks to amplify the standpoints of those who are oppressed (Frey et al., 1996). I am particularly interested in how standpoints are negotiated during the reiterative stages of analysis, interpretation, and writing- the point at which knowledge becomes concretized, inscribed in text, and is at the precipice of publication.

The field of critical health communication has engaged deeply with questions of power, language, meanings, ideology, and materiality as expressed in discursive practices; it has also paid attention to western imperialism, global capitalist institutions, colonial and postcolonial relations, and dialectical tensions inherent in discourses of modernization and development (e.g., Dutta-Bergman and de Souza, 2008; Zoller and Dutta, 2008; Rastogi and Dutta, 2015; Sastry and Lovari, 2017). However, much less has been written about the micro-politics of knowledge production. Feminist scholars assert that we must analyze the micro-political processes involved in our research in order to answer questions about the political economy of knowledge production- how is knowledge produced, who produces it, and how does it becomes privileged? (Haraway, 1988; Bhavnani, 1993). It is precisely this underbelly of critical health communication research that I would like to make visible. I draw on examples from my own now published research over the past decade in two different settings: HIV and AIDS in India and hunger and food insecurity in the United States to explore this dilemma. I use double-blind peer reviews from manuscripts submitted over the years as well as open reactions by peer reviewers, reviewers, editors, students, and other institutional actors to show how hegemonic worldviews operate from behind the scenes to shape the writing and presentation of research.

This article makes a practical and theoretical contribution to the field of critical health communication and the broader field of qualitative research methods. The overarching concern of this paper is with the exclusive and privileged nature of communication research and social research more broadly. Race is "one of the most viable and reliable analytical tool for understanding and improving the collective fortunes of people of color in the United States and globally" (Donnor and Ladson-Billings, 2018, p. 353). Yet, the barriers put up via formal and informal gatekeeping choke the emancipatory potential of communication. Anthropologist Douglas Foley (2000) ends a rather tortured essay on his own standpoint as a white male researcher studying Mexican American activism stating:

> For years I have been hearing tales about how the White male-dominated disciplines, professional associations, and publishing game pressure "minority scholars" to be politically correct. Ethnic minority, feminist, and gay and lesbian scholars also need to expose how such pressures compromise their scholarship. It will be good for their souls and for the academy (p. 79).

This paper responds to calls made to expose the more subtle pressures and demands the white academy places on researchers of color and the impact it has on our work and us. Theoretically, this article makes a contribution to qualitative research methods by unmasking and refining what it means to "work the hyphen" as a scholar of color. Once we trouble the assumption that *all* researchers speak from positions of power and that academia is a neutral non-ideological unraced space, then "working the hyphen" takes on new meaning. Because power operates differently researchers of color in white spaces, reflexivity for these researchers must look very different from the "thoughtful self-consciousness" of white researchers. This has implications for the credibility of our work and how it is evaluated.

UNMASKING THE SELF-OTHER DICHOTOMY

While there is a robust literature on reflexivity and how to navigate the Self-Other hyphen, much of it is written by and for white people going into communities of color. Even as this literature draws on the work of Black and Third World feminists (e.g., Mohanty, 1993), an unfortunate blind spot in this very progressive literature is that people who do research are white, while people being studied are "Other." Fine (1994) writes that the "Self and Other are knottily entangled" in the research process making it critical for qualitative researchers to locate themselves in the research process (p. 72). "Working the hyphen" is a way to resist the imperializing gaze of western Christianity and manage tensions with outsider (etic) approaches to culture, where the ethnographer and the "observed" hold different values. Fine (1994) carefully observes:

> When we opt, as has been the tradition, simply to write *about* those who have been Othered, we deny the hyphen. Slipping into a contradictory discourse of individualism, personalogic theorizing, and decontextualization, we inscribe the Other, strain to white out Self, and refuse to engage the contradictions that litter our texts. When we opt, instead, to engage in social struggles *with* those who have been exploited and subjugated, we work the hyphen, revealing far more about ourselves, and far more about the structures of Othering (p. 72).

There are several useful directives and guidelines for qualitative researchers going into "Other" spaces. To prevent reinforcing stigmatizing frames, researchers are asked to "write against othering" by interrogating their own standpoints and positionalities in the world. The literature cautions researchers to be mindful of their personal and social privilege, to strive for increased transparency, to describe context "thickly," to give participants voice, to connect the stories of individuals to historic, structural, and economic relations in which they are situated, and "to do no harm" (Fine, 1994; Fine et al., 2003). Best practices also include not withholding crucial information and knowledge from research participants, an increased openness with participants about the goals of the research, allowing research participants to shape research questions and have "voice" in the data (Hurtado and Stewart, 1997). While researchers are not necessarily asked to kowtow to participant interpretations, qualitative researchers are directed to describe contexts thickly, show multiple perspectives, show richness and contradiction, and allow readers to draw their own interpretations about meanings and significance (Patton, 2002; Ellingson, 2009; Denzin and Lincoln, 2018).

In the course of my research, I found myself scouring through the literature looking for guidance on how to navigate my own racial unevenness in the research process as a person of color navigating white-dominated spaces. The established guidelines made sense some of the time, but not all of the time. Reflexivity surrounding race and class were addressed in the literature, but the researcher was assumed to belong to the racially dominant group. The question of whether or not to share the emerging analysis and interpretation of data with dominant actors- and how to do so- was also left unanswered. When is it appropriate and in what settings is it appropriate to share such an analysis with powerful stakeholders? As a woman of color conducting research in white spaces what are the added challenges of doing so? In addition, the micropolitics of research, particularly the meta-labor of tiptoeing around the ideological stances of academic actors were usually not addressed.

There were only a few scholars who discussed the issues that I was grappling with. For instance, Hurtado and Stewart (1997) noted that while feminist epistemology had developed methods, guidelines, and "best practices" to affirm the marginalized perspectives of participants, but the same question had not been answered in the study of whiteness. "How do these suggestions, flowing as they do from a concern about the power imbalance between researcher and the researched, fare when we turn to research on whiteness?" (p. 307). They note that recording and repeating racist views of participants only reifies racism in an already racist society. So instead, they argue for maintaining a "critical, counterhegemonic presence" in the research: "When exploring hegemonic experiences like whiteness, the trick is to find ways to retain a critical, counterhegemonic presence in the research" (p. 309–310). Furthermore, they point out that "thick" description or "giving voice" must give way to "thick" analysis and holding ourselves and others to "a very high standard of analytic depth" when work carries a risk of causing suffering in those already the objects of daily racism (p. 307).

Feminist and critical race scholar Bhavnani (1993) similarly pointed out how feminist epistemology had erased, denied, ignored or tokenized contradictory and conflicting interests and standpoints of women from all around the world. A key question she posed was: "how and to what extent does the research conduct, write-up, and dissemination deal with the micropolitics of the research encounter- what are the relationships of domination and subordination which the researcher has negotiated and what are the means through which they are discussed in the research report?" (p. 98). She analyzed her own interviews with young white working class people in Britain and found an unevenness on both sides; her racialized and gendered ascriptions suggested that both structural dominance and subordination were in play for herself and her interviewees. She writes: "What I am suggesting is that an inversion of this "normal" power imbalance in research studies- from the conception right through to the analysis- can permit a sharper analysis of the micropolitics of research, so that *feminist* objectivity can be implemented. So, any text which emerges in a research encounter cannot be taken for granted (p. 102)."

The work of sociologist Bonilla-Silva (2010) on color-blind racism also provided a way forward through methodological terrain fraught with struggle particularly with regard to analysis and interpretation. He noted, as many do, that interpretations are always infallible and neither the researcher nor their potential critics hold a monopoly over the right way of interpreting data. But then he added this statement, which for me captured the tension I was experiencing and helped make the path less foggy. "All of us try our best to construct robust explanations of events and hope that in the tilted market of ideas (*tilted toward interpretations of the powerful*) the most plausible ones achieve legitimacy" (p. 14, emphasis added). As to the burning question of trustworthiness and credibility of his own research, which had clear theoretical and political orientations, he wrote: "Judge my cartographic effort of drawing the boundaries of contemporary white racial ideology in terms of its usefulness (Does it help to better understand whites' views?), accuracy (Does it accurately depict whites' arguments about racial matters?), details (Does it highlight elements of whites' collective representation not discussed by others?), and clarity (Does it ultimately help you move from here to there)" (p. 15). In my analysis of whiteness in food pantry settings, these criteria became far more valuable to me than engaging in direct debate and argumentation with particular research participants or groups and/or attempting to achieve consensus around interpretations. That would come later perhaps, but for now the dynamics of power and subjugation in the research setting were far too uneven on all sides. Instead I focused on these questions: Is my work useful, descriptive and detailed, and does it help us move from here to there? "There" being a vision of food and social justice. I shared the emerging analysis informally with broader groups of people from dominant and non-dominant social locations and in and out of food pantry settings. The feedback and reactions were useful for both supporting the analysis and ascertaining counter-interpretations and viewpoints. I also observed that since I was swimming in white-dominated culture, accessing hegemonic arguments was relatively easy. These viewpoints were neither invisible nor absent. They constantly exerted pressure on me to shift the analysis. In fact, maintaining a counterhegemonic presence in the face of these dominant forces was no easy task. So in going about my work, I attempted to address all the counter viewpoints in the writing itself while struggling to maintain and "own" my position. This was not a linear process and involved a great deal of emotional, intellectual, and embodied effort.

In what follows, I provide three examples from my own research on HIV and AIDS in India and hunger in the US to illuminate how the micro-politics of research and power-inversions shaped my writing and the production of knowledge.

"THICK DESCRIPTION" OR "PRIMITIVE FACTS"?

A standard metric for evaluating the credibility of ethnographic research is "thick description"—a technique advanced by anthropologist Geertz (1994) as a way to move from a more scientific style of writing up the data to a more literary style showcasing local wisdom and *in situ* knowledge. What makes an ethnographic description "thick" is not that it mirrors true reality but that it holds "intelligent, richly detailed, locally significant, and intricate accounts constructed by the ethnographer" (Chen and Pearce, 1995, p. 144). Geertz (1994) noted famously "the value of an ethnographic account does not rest on its author's ability to capture primitive facts … but on the degree to which he is able to clarify what goes on in such places, to reduce the puzzlement" and "to sort out the winks from twitches and real winks from mimicked ones" (p. 222). For Geertz, the ability to show distinctions and deeper meanings behind interactions was at the heart of "thick description," not necessarily a focus on descriptive details for their own value. However, this is not always what counts for thick description in a historically white academic context.

Given that ethnographic work came about as a way to know the Other and is still used for those ends, thick description is often simply a way to capture primitive facts, rather than identify deep distinctions. Rather than a means of "writing against othering," thick description becomes a way to compensate for that which the audience does not recognize about the Other, and in so doing puts the Other on display. Fine (1994) writes:

> The imperialism of such scholarship is evident in terms of those whose lives get displayed and whose lives get protected by social science. Put another way, why don't we know much about how the rich live? Why don't we study whiteness? How do "their" and "our" lives get investigated (and not)? Whose stories are presented as if "naturally" self-revealing and whose stories are surrounded by "compensatory" theory? (p. 73).

As I reflect on my work on HIV and AIDS in India, I realize how seemingly benign requests for "more context" from peer reviewers functioned as a mode of imperialism in my work. As a researcher studying "my" people in India, every article I submitted for peer review came back with demands for more descriptive details. I recognize now that I was disadvantaged because what was taken-for-granted in my mind needed to be described in great detail for a predominantly white western academic audience and peer reviewers. In every case, reviewers made demands for primitive facts and even generalizations, stereotypes, and frames that would be familiar to their own racial cognitive schemas as seen here:

> Page 20, I am just curious as it makes it sound like widows of HIV patients are outcasted but isn't common in many parts of India for widows to be outcasted? Perhaps, this population faces additional challenges and difficulties (though the author does bring this point out later in the section) but again the discussion ought to be located in power for/in empowerment where the author notes "family are provided with communicative platforms & skills" (i.e. trained for power-with).

Here is another example from a different article on the role of biomedicine in the lives of people living with HIV and AIDS:

> The analysis of how the Western biomedical paradigm displaces and/or is re-articulated as "folk" knowledge is intriguing. However, it would be useful to provide some context as to how this process occurs. For instance, what are traditional "folk" definitions of disease in India and how do they compare to those offered by biomedicine?

These requests for compare and contrast type analytical frameworks juxtaposing tradition with modernity occurred with great frequency in my manuscripts. Even as my own article attempted to interrogate orientalist assumptions underlying the use of the term "folk" in discussing meanings of medicine, I was being asked to make a distinction between the two. Reflecting on these interactions, I realize that the purpose of requesting these descriptive details was to allow the Other to fit within dominant cognitive schemas—in this case orientalist and "white racial frames" (Feagin, 2013)- and doing so in fact increased the credibility of the research in this particular venue.

The next example shows how white racial frames operate from behind the scenes to shape the writing of the research. Here my peer reviewer commented about their lack of contextual understanding surrounding commercial sex workers (CSWs) in Bangalore India. These were sex workers who were being organized by a local non-government organization called SPAN for HIV prevention and support.

> Later (pg. 18), Geeta's dialogue indicates that a madam is part of SPAN (and wow does that need to be explained) and that it was this Madam that initiated the formation of Sangha [organization]. I have to be honest, I clearly don't understand the culture and my very ethnocentric understanding of prostitution is largely a function of Western media like *Law and Order: Special Victims Unit* or the Madam with the heart 'o gold in "*Best Little Whorehouse in Texas*." So, in addition to clarifying just how SPAN helps these women, you need to help readers understand the social and political context of sex work in India.

I remember how sick I felt on reading this particular comment. I had a visceral embodied reaction. I was disturbed that this reviewer had compared women in India living with HIV at the bottom of every rung of every social structure to Hollywood productions- and quite flippantly at that. As an avid consumer of *Law and Order SVU* myself, I had never made that connection. It did not occur to me that anyone would make that connection- and dare to speak it into being. As a researcher, I was troubled because I thought I had done enough to contextualize this group of Indian women already. The paper already talked about the abuse the women experienced in the hands of police, pimps, and clients, what more was required really? In retrospect, this comment was typical of how the directive for thick description is often employed to capture primitive facts. This was not thick description that showed the difference between the twitches and winks that Geertz talked about, but here broad brush strokes had come to stand in for thick description. In the end, I deleted excerpts from the interviews and replaced them with about five hundred words describing in somewhat static terms the social location of my participants.

This reviewer's comment was a defining moment in my career as a critical communication scholar. In this moment, as an untenured assistant professor, I was very swiftly made aware of the immense social distance between us: the reviewer and a very white discipline of communication on the one hand and myself and my participants on the other. The Self and Other were awkwardly merged and articulated in these pieces of writing. I was placed in an odd position of being both Self and Other and both insider and an outsider. I was a member of the group under study and of the elite research community. I was an outsider to the group I was studying and an outsider of the elite research community. I was the writer, but there were several other writers who were shaping my writing from behind the scenes. So many times I simplified, generalized, and fit information into recognizable western cognitive schemas. In so doing, one could argue that my research had become a cavern for a more subtle kind of imperialism where the Other was put on display for an elite academic community. In these articles, the stories of the women and men that I talked to could not be made to appear normal, but were Otherized by an orientalist fetish. My participants had their lives displayed, I had my commitments displayed as a researcher and a brown woman, but the white academic institution operating in the background and from the sidelines, remained hidden and unexposed in the text.

CHALLENGING THE "THICK DECRYPTION OF SUBTEXT"

In my more recent work on hunger and food insecurity in the United States, which explored the operation of race in food pantries, I faced a slightly different challenge with regard to thick description of context. In a "racism gone under" context, racism has quite literally gone under making it a challenge to study. In color blind post-racial contexts, traditional instruments like surveys and interviews with direct questions about racial attitudes and actions are not able to identify racial issues—they do not uncover the variety of ways in which racism expresses itself (Bonilla-Silva, 2010). For instance, although not explicit, race is typically the subject just beneath the surface of terms such as welfare, urban, crime, and poverty, which are terms used strategically to evoke people of color (Gilens, 1999). Winant (1997) points out that since the 1960s racial discourse has been unable to function as a logic for racial superiority and justified exclusion. "Therefore it has been forced into *re*articulations, *re*representations, *re*interpretations of the meaning of race and, perforce, of whiteness" (p. 40). This means that our methods must be able to identify and make visible these rearticulations, rerepresentations, and reinterpretations. Hurtado and Stewart (1997) talk about the need to move beyond thick description to thick analysis and "a very high standard of analytic depth" in these situations (p. 307). Wellman (1993) and Frankenberg (1993) write about the importance of using rich layered sociohistories to reveal the subtleties and complexities of racism, beyond the most obvious kinds.

Since racism is often concealed in text, structures, policies, and environments, in my work I have found that I also need to thickly describe and analyze not just what is visible, but what is invisible- the subtext and "absent presences." The "presence of an absence" may be thought of as the figurative presence of race and racism, even in the virtual absence of people of color (Rosenberg, 1997, p. 80). Uncovering absent presences requires excavating beneath discursive practices for ideological assumptions and orientations. I refer to all of this deep analytical work as the "thick decryption of subtext" as opposed to the "thick description of context." For researchers using middle-ground qualitative approaches and with healthy commitments to empirical evidence, accounting for absence requires detailed work. Since the evidence is no longer about what is observable by its presence, but what is observable by absence, a challenge is posed to credibility. For instance, in the case of Chum[5], one of the more liberal food pantries that I studied, I made the argument that even though public relations materials identified economic factors that brought people to food pantries, there were discursive erasures with regard to historical and contemporary patterns of racial inequities. The public relations materials went out of their way to speak around racism. Explicit language about the problem of racial inequity was absent, although present were several images of people of color who were being helped by Chum's work. In light of this evidence and more, I argued that even though racial inequity remained unarticulated, there was a racial subtext to the discourse.

In another example from Ruby's Pantry, the more conservative food pantry that I studied, I described a letter written by Lyn Sahr, the pastor and founder of the pop-up food pantry network. In his letter, Sahr used a Bible verse to draw the connection between laziness and material poverty: "A little sleep, a little slumber, a little folding of the hands to rest—and poverty will come on you like a bandit" (Proverbs 6:10–11). In Sahr's interpretation, it was not structural or historical factors that created poverty, but rather the "poverty bandit." The text had embedded within it an image

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[5] This research study was based on a comparative case analysis of two food pantries in Duluth, Minnesota: Chum and Ruby's Pantry. The pantries varied in religious and political orientation, organizational structure, quantity and quality of food distributed, clientele, and relationship to the state. Chum is a politically liberal organization, uses a social justice lens in its work, and receives government funding. RP on the other hand is rooted in evangelical conservative leanings, makes no claims about social justice, and positions itself in opposition to government programs.

of a Black man—the paradigmatic racial Other- with a shaved head. The man is holding his head in his hands and leaning over a desk, with one arm extended into a clenched fist because presumably the poverty bandit had stolen his dignity. It is one of only three images found across the sample of Sahr's letters. Here too I similarly made the argument that even though there was no direct racism in the letter, the underlying interpretive context for this message was anti-Black racism. I made the claim because of the text of the letter itself, the imagery that accompanied the letter, the larger context of Sahr's letters, and the extant literature that has started to decode rearticulations, rerepresentations, and reinterpretations of racism.

However, in these instances, the lack of explicit racism in the texts combined with my thick decryption opened the door for dominant actors to contest the claim. In highly engaged discussions[6], my white students called into question the credibility of my claims using the language of "coincidence"- well perhaps it was just a coincidence that these pictures were chosen and maybe it did not mean much that they were embedded in the text. Perhaps they were just "stock images." Sahr sounded like a good man helping others, but here I was putting the pieces together in a different way that cast a shadow. A defining moment in my own reflexive journey occurred when one student started to grill me: "Do you think Sahr is a racist? Is he a racist? What do you think?" This caught me off guard. Everything within me began to scream. I thought I had laid the evidence out so clearly. Wasn't this so obvious? Was it me or him- my student? Maybe I had managed to hide myself amid the analytical depth. Did this white male student, a self-identified liberal want some kind of odd closure? Did he want me to say the word "racist" so it would resolve something in his mind? To his disappointment, I did not answer the question. Instead I told the class that the goal of my research was not to hunt out individual racists — a phrase borrowed from Bonilla-Silva (2010), but to unpack deep-seated ideas that upheld systemic racism. But they were of course free to identify racists based on their own discernment of the evidence. Another student piped up "I think Sahr is a good man, he just wants to help out."

The reactions of my students informed the writing of my research in that I painstakingly rewrote each chapter of the book to respond to such hegemonic stipulations and to clarify my own standpoint. The analysis, much to my horror, had left too much room for interpretation. The methodological directive to describe thickly and allow people to draw their own interpretations about meanings (e.g., Patton, 2002) was flawed in this context. The invitation to see nuance and subtext had been received by my readers as an invitation to maintain hegemony. In this instance, working the hyphen meant recognizing that my work was indeed ideological (as all research is), but that this ideology had life and death consequences for people of color. In addition to the names, faces, and voices of my participants like Xavier, Antoine, Gabrielle, and Trinity, I could not stop another litany of names scrolling through my head: Eric Garner, Michael Brown, Jamar Clark, Tamir Rice, Freddie Gray, Stephon Clark, Alton Sterling, Philando Castile . . . This was the historical moment I was writing within and I did not ever want my readers to doubt where I stood. So I used my authorial privilege to revise the book. My goal was to provide enough description so people could interpret the data for themselves, but to also be clear about what *I* as the researcher thought the data revealed. I did this by using a series of questions to acknowledge the viewpoints of dominant actors followed by unequivocal concluding statements—a final word so to speak. In this particular instance of the Black man and the "poverty bandit," I ended with this statement.

> All in all, this text now joins the deluge of discourses circulating in society that reinforce age-old racist assumptions and stereotypes about people of color being poor and lazy, while absolving the roles of capitalism, structural racism, and a whitened Christianity in producing racial disparities.

When I read this statement now, it sounds easy and the writing even flows. But I wrote and rewrote this statement a hundred times. I remember the clicking and clacking sounds of the keyboard interrupted by silence calling to mind the profane and sacred wisdom of Gloria Anzaldúa:

> *Write with your eyes like painters, with your ears like musicians, with your feet like dancers. You are the truthsayer with quill and torch. Write with your tongues of fire. Don't let the pen banish you from yourself. Don't let the ink coagulate in your pens. Don't let the censor snuff out the spark, nor the gags muffle your voice. Put your shit on the paper* (Anzaldúa, 2015, p. 171).

WHITE FRAGILITY IN ACADEMIC SPACES

To have white privilege is to always be surrounded by pro-white meanings, analytical frames, and interpretations, so when claims, assertions, and conclusions are offered that do not employ a pro-white bias, the result is racial defensiveness. White fragility is defined as:

> a state in which even a minimum amount of racial stress becomes intolerable, triggering a range of defensive moves. These moves include the outward display of emotions such as anger, fear, and guilt, and behaviors such as argumentation, silence, and leaving the stress-inducing situation. These behaviors, in turn, function to reinstate white racial equilibrium (DiAngelo, 2011, p. 54).

A key burden that scholars of color face in writing about whiteness in a white academy is that whites do not know themselves as a group. Whiteness is not an empty cultural space, but a social location and a way of life lived in separation from the Other (e.g., Kobayashi and Peake, 2000). However, until recently

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[6] The class conversations depicted in this paper came from the course titled "*The Politics of Food, Health, and Communication*" – a required senior capstone seminar for communication undergraduate majors. The course content centers on the research interests of individual faculty members. The course format is akin to a graduate-level course with small class sizes and a focus on reading, discussion, and peer teaching and learning. While a requirement, students choose from among 3–5 different courses each semester led by different faculty. In my course, I spend much time building rapport with students and creating a safe space for reflection, discussion, and argumentation. Student evaluations confirm that students experience the course in this way and appreciate the opportunity for frank conversation.

whites have not had a way to understand the psychological meaning of their race and the material implications of being raced (Carter, 1997). One way the lack of conscious awareness is expressed is in resistance to critiques of whiteness and opposition to even a most neutral analyses of whiteness that does not include a pro-white bias. Indeed, similar to Hurtado and Stewart (1997), I have learned in the course of my research that: "although few can articulate the privileges that whiteness brings, most can detect when whiteness is being questioned and its privilege potentially dismantled" (p. 303).

In my research on hunger, I observed that most white people showed little stress or discomfort talking about racism and racial inequities in general, but when the lens shifted to focus on whiteness there was discomfort. I received no challenges to my analysis so long as it fit within the cognitive schemas of dominant actors. The topics of oppressed Black and brown people, poor neighborhoods, and food deserts were tolerable. Indeed, there was empathy for the Other- American Indian and African American clients of food pantries. I described the context of people's lives, the reasons they came to the food pantry, the stressors they lived with, and the aspirations they carried. I connected the stories of individuals to historic, structural, and economic relations in which they were situated including Jim Crow and the genocide of indigenous communities. White institutional actors who read the chapter responded in normatively appropriate ways—they showed empathy, shook their heads in disgust at the stories of abuse, and accepted the historical evidence.

However, all of this changed when I shifted the lens to make claims about whiteness honing in on the interactions between white food pantry volunteers and Black and brown clients. In my work, the most fragile responses came from reviewers, editors, and undergraduate students who read versions of the book chapters. In one of the chapters, I wrote about Lisa, a long-term volunteer at the Chum food shelf, who brought her daughter to the food shelf to teach her that the clients are "no different" from her. To demonstrate whiteness, its motivations, and structural privilege, I wrote about how Lisa gives to charity, but also how her life is lived in complete separation from the Other.

> Her family lives in a rich neighborhood, all their friends are wealthy, and her daughter goes to the best school in the city. Volunteering at Chum is a way to expose her daughter to people who are not wealthy and do not live like they do. The pedagogical goal is to show her daughter that They are just like Us and that moving between one "category or camp" and another is simply a matter of employment and who gets to keep their jobs.

I used this set-up to assert that neoliberal stigma is reinforced through color blind articulations that do not engage with the deep histories and political contexts of people of color.

I had three sets of senior undergraduate students over 3-years read drafts of this chapter finally titled *The "Good White Women" at the Chum Food Shelf*. The conversations, the remarks, the resistance, the gut-wrenching honesty, and the one white female student who between broken sobs said to her classmates, while avoiding glancing in my direction, "you know, how they're saying *those* good white women, you know they're just, you know, they're just nice women." In this instance, completely unaccustomed to seeing white women grouped together in a particular racial formation complete with cultural patterns and behaviors, the student's racial comfort was disturbed. As a Third World woman of color, who has had many things said about her, I could empathize. Indeed, more than a few white students thought I was making unfair claims about Lisa. Some thought that it would not have not been age appropriate for Lisa to talk to her daughter about such things. Many were honest and said that they too would have possibly explained the food pantry in that way. They wanted me to affirm that I was not calling her a racist- which I was not. I was making a point about whiteness. Lisa is not necessarily anti-Black, but rather she is incredibly white, not in an essentialist way but because of the connection between "privilege property, and paler skin" (Slocum, 2007, p. 521). Lisa was an active participant in the system of whiteness, thereby contributing the systemic oppression of the Other.

Since whiteness is rarely scrutinized, any attempt to examine it results in fragile responses. People of color have typically been the targets, objects, and subjects of investigations, while white people (and whiteness) have been construed as normal, normative, and unproblematic. Fine et al. (2003) write:

> Across the social sciences, scholarship has fetishized "people of color" as the "problem to be understood" to the extent that whiteness, in all its glistening privilege has evaporated beyond study. One of the ironies of white power is the ability to escape social and intellectual surveillance (p. ix).

Putting whiteness under scrutiny is unsettling because it creates uncertainty; the project is no longer about hunting out individual racists, but about putting white culture in all its "glistening privilege" under the microscope. For white folks who have not yet committed to the project of anti-racism, it makes them feel distanced and different. The study of whiteness produces cognitive dissonance with regard to identity- there is a lag between how they perceive their behaviors and my interpretation of those behaviors. In fact, most have never thought of themselves as even belonging to a racial group! This leads to emotions ranging from anger to defensiveness to sadness. In light of these fragile responses, I rewrote the chapter many times using the same technique: a series of questions acknowledging dominant views and concerns followed by analyses and statements to maintain a counterhegemonic presence in the research. For instance:

> Is Lisa ignorant? Is Lisa a racist? Does she think her daughter is too young to understand racial issues? Is she being politically correct? There are many ways to rationalize Lisa's discourse, but even so we must at least recognize two key points. First, Lisa speaks from a racialized position of whiteness. . . .

I coupled these questions and attributions with the concluding statement:

> Even as communities of color prepare their 3- and 4-year-olds for the white terror that will be unleashed upon their bodies, Lisa's daughter is spared an education in systemic racism because it does not affect her.

It is not easy to maintain a counterhegemonic presence because challenges can come from anywhere, anytime, and when you least expect it. The next example from the same chapter depicts one such struggle. This comment came from one of the many editors who went through the book with a fine-toothed comb; she caught typos, analytical errors, and missing evidence and I was very grateful and impressed by her thorough work. In this chapter I described Penny, a white female volunteer at a local food pantry, who talked at length about how she had been called a racist by a Black female client. Penny started out her description of the event saying "Well, there was actually one client, a lady in particular who was a little more prickly. . . . " In my original manuscript, I started with this assertion.

> Significantly, Penny starts out the story *without* identifying the lady as African-American, but by using the racially coded term "prickly lady" we already know the race of the client, because it is a term laden with ideological formations surrounding Black female aggression.

The analysis then moved on to unpack the episode through the lens of white fragility (Penny's fragility) and racial stigma. I thought I had done enough to substantiate my reasons for asserting that "prickly" was a racially loaded term. Since stigma and stereotypes were the subject of the book, I had outlined these conceptual themes quite thoroughly in the first two chapters of the book. However, the editor made this comment regarding my assertion.

> Just curious—is this something there's actual research on? I for one wouldn't assume anything race-related based on that term; to be honest, it makes me think instead immediately of my grandmother on my father's side, who was pretty decidedly white. Heck, I've been known to describe myself as being in a prickly mood when I'm feeling irritable.

My immediate reaction to this comment was visceral. I felt anger rise within me. I had spent no less than three years working and reworking this one single chapter about whiteness in response to white fragility. More importantly, I had just spent the last three chapters arguing for how we should listen to the voices of the hungry and not argue with them from our privileged standpoints. In fact, the previous chapter documented in great detail the voices of food pantry clients. The editor might have simply asked me to unpack my assertion more, but tellingly she asked for proof. Is there actual research on this? I wondered if white researchers writing about people in India or about people of color in the United States had their claims checked in this way. I have heard from colleagues about how they get so "angry and mad" with negative peer reviews, that they have stacks of articles that have never been revised. As a woman of color, a nonresident alien and then an immigrant, this kind of walking away has never been in my knapsack of privileges. I spent the next few deeply disturbed days reflecting and being reflexive about *how* I knew what I knew and why she the editor had said what she said. In doing so, I realized a few things: what I took to be a basic even primitive fact was for her an opinion that needed substantiation. I knew the racial code, but she did not. I was an expert by experience and training and that's how I knew the racial code. My editor as a white woman had identified with Penny. She knew her, she recognized herself in her and understood her, and so my assertion came up short. My editor related more deeply with Penny than to me or the Black woman in the story. Furthermore, she interpreted our difference of opinion to be just that- a benign difference of opinion. She did so because like Penny, she had disconnected the interaction from deeper historical, structural, and economic relations. The empathy produced by the previous chapters- which had put on display the struggles of food pantry clients- had quickly evaporated. In an instant, we had hit the very same wall of whiteness. Yet again here was another white woman with the very best of intentions attempting to reshape and redirect the equitable production of knowledge.

It took a few days for me to stamp out my anger and then a few more to recognize my own power. In this setting, I was no longer the untenured faculty seeking to build a publication record. The manuscript had already been accepted by one of the top presses in the country and was about to go to print. It would be published whether or not I chose to respond to the editor's claim. But I also realized that if my editor, a smart cogent self-identified liberal white woman (she had mentioned her political leanings in an earlier comment), did not trust the assertion of mine, there was a big chance that the claim would lack credibility with other whites as well. This credibility was important to me given the social justice imperative of the research. I was writing this book for people in positions of power, specifically good whites engaged in "ending hunger," with the hope that they would see their charity in a new light. I realized that a higher standard of analytic depth was required to unpack the "*re*articulations, *re*representations, *re*interpretations of the meaning of race and, perforce, or whiteness" (Winant, 1997, p. 40).

So I then switched into survival mode, set my face to stone, and dug in. I was incredibly relieved to find Black feminist and legal scholars who had done the intellectual work of studying the "angry black woman" (ABW) stereotype (e.g., Walley-Jean, 2009; Jones and Norwood, 2017). I wondered what barriers they faced in bringing these works to publication. I used their work to substantiate my claim and to provide an even stronger counterhegemonic presence in the research. So after what seemed like a lifetime had passed, I responded to the comment made by the editor in this way:

> Yes! Tons of research on "the angry black woman" stereotype- and the language codes and manner of interaction. Prickly is benign when whites use it for themselves or other white people, but it is problematic in interracial contexts- especially like these. Context is key here. Your question/comment was an important one- and I realized I needed to add more here in terms of citations and contextualizing. I have done so- so it has changed a bit from the original. These are the three pieces newly cited here. The law review is a really good article- in case you are wanting to read about it.

Similar to the literature that I had just cited on the ABW stereotype, my response to the editor was prosaic, professional, and wiped clean of anger, pain, and struggle. I retained my initial assertion in the book, but added about 200 words citing three hefty publications including a law review. I revised my original assertions to now read in this way:

> However, in her use of the term prickly lady, I was already primed for the race of the client, because in this context, the term prickly fit precisely within the trope of the "Angry Black Woman" (ABW)....

CONCLUDING COMMENTS AND RECOMMENDATIONS

It is important for scholars of color to debunk assumptions, including our own, that academic spaces are neutral, non-ideological, and un-raced. In my own work, I have learned that navigating the Self-Other hyphen means recognizing that "thick description" when interpreted merely as *description* of primitive facts can function as a mode of imperialism in the research. I have also learned that when studying whiteness, the worldviews of gatekeepers can function to suppress the voices of participants of color and my own voice. As scholars of color, we have a whole host of power similar to white researchers in that we ask questions, present and represent participants, and engage in the analytical work to make sense of findings; however, we are also disempowered in academia when advancing counterhegemonic claims. People of color whether as researchers or writers are often undermined as producers of knowledge (Collins, 1990; Mohanty, 1993; Anzaldúa, 2015). This suppression harms our careers, our mental and emotional well-being, and is an unseen impediment to the construction of knowledge. Cook (1997) argues that white dominance in academia is both about demographics and dominant value systems.

> One obvious reason for identifying academia as "White" is that in many instances in predominantly White colleges and universities, the academic departments consist of a resounding majority of White faculty members. Thus, the demographics create an environment of "Whiteness." Perhaps less obvious is that the value systems upon which academic departments routinely function reflect the values of Western European, or White American cultural values. Furthermore, cultural racism within White academia is such that the White cultural values are strictly enforced and built into the power structure of academic departments (p. 101).

When scholars of color go into the field to interview, to observe, and put forth assertions about people in dominant and non-dominant locations, the implications and considerations for working the hyphen are dramatically altered. To overlook this kind of role reversal between the Self and Other is to reinforce a "one size fits all" measure of validity in qualitative work that fails to account for the intersectional identities of researchers and the interflows of power that shape the construction of knowledge. That said, the Self-Other hyphen also provides an appropriate conceptual framework in which to boldly make visible our bodies, our writing, and our struggles with power—and in so doing enhance the credibility of our work and dismantle an inequitable political economy of knowledge production. To this end, I offer a few practical recommendations for navigating the hyphen from below and establishing criteria by which our work can be evaluated.

First, we must write openly and explicitly *in our texts* about the ways in which hegemonic forces have shaped our research. As researchers, we are adept at discussing our privilege in the "reflexivity" sections of our manuscripts, but less so at naming our marginalization. This is not a call to overstate our powerlessness, because indeed we are privileged in many ways, but to also not understate our marginality. This is also not a call to saturate our texts with narcissistic reflections, but a call for more transparency in how our works are produced and co-produced. In her work on crystallization, Ellingson (2009) writes that reflexive consideration of the researcher's self in the process of research design, collection, and representation may be incorporated in an appendix, footnotes or endnotes, interludes or even a separate cross referenced or linked text. For scholars of color, these notes and interludes must also include ways in which academic gatekeeping has functioned in our work either by suppressing counterhegemonic claims or by allowing voices from below to flow freely into the canon of constructed knowledge. If research methodology answers the questions: "how did this knowledge come into being?" then acknowledging the role of gatekeeping in constructing and obstructing knowledge is critical. Of course, it is risky to write about these concerns prior to works being accepted for publication, but when possible, we should add these notes once our articles have been accepted for publication, or alternatively, find other avenues to publish these reflexive pieces. We are fortunate to live in a moment in history when whiteness is fissured and there are many "varieties of whiteness" (Winant, 1997, p. 40). This means that in my own case there were several white men and women in the academy who reviewed my work, affirmed its value, credibility, and trustworthiness, and permitted it to see the light of day. Making note of these cracks and fissures are equally important for naming our historical moment and interrogating the political economy of knowledge production.

Secondly, it is necessary to find ways in which to maintain an unswerving counterhegemonic presence in critical qualitative research. This does not mean merely presenting a smorgasbord of multiple perspectives in which a counterhegemonic perspective is one of many. Rather, it means exerting our authorial power to saturate the writing not only thick description of context, but also "thick analysis" and a "thick decryption of subtext." This means packing the analysis with questions, standpoints, hard data, case law, and cross-disciplinary research. It means going back in time to narrate the role of history, biography, and intergenerational trauma and its consequences on people of color today. It means locating people within racial hierarchies and holding them accountable for their views. Fine et al. (2003) ask: "Have I connected the "voices" and "stories" of individuals back to the set of historic, structural, and economic relations in which they are situated?" (p. 199). This ethical injunction is appropriate not only for the voices of the oppressed, but the voices of privilege as well. In my book there were many sections in which I wrote about how present day hunger and food insecurity are linked to slavery, Native genocide, and Jim Crow. However, what I did not do was probe my white participants about their history of relative privilege. Which of their families got to own farm land and infrastructure because of institutionalized discrimination by the United States Department of Agriculture? Which of their families got to own homes and inherit wealth because of the racist Federal Housing Authority? Which of their families owned slaves? Who participated in the Civil Rights movement and who didn't? My white participants did not bring up their racial histories and it did not occur to me to investigate. However, interpreting Fine's directive from a racial justice imperative means that it is just as important to connect the "voices" and "stories" of Others to historic relations as it to connect the voices of dominant groups. For too long whiteness has escaped social and intellectual surveillance and this is one way thick analysis can be used to reveal long-standing racial imbalances while maintaining a counterhegemonic presence in the research.

Thirdly, as scholars of color, we must constantly remind ourselves that truth is not consensus. This means attending carefully to how consensus and debate are navigated in the analytical and writing process. Geertz (1994) argued that "to commit oneself to a semiotic concept of culture and an interpretive approach to the study of it (*sic*) is to commit oneself to a view of ethnographic assertion as 'essentially contestable"' (p. 230). Ethnographic assertions are indeed "essentially contestable," but not always in benign ways. In fact feminists like Chandra Talpade Mohanty (1993) warn against the empty pluralism of "harmony in diversity" perspectives that bypass power, history, and struggle (p. 72). As a researcher of color who has received "contests," identifying and naming the source of these disagreements has been crucial to working the Self-Other hyphen. Who contests, who protests, and who concurs? Why does it happen and what kind of pattern does it follow? If we do not recognize these patterns, then we end up feeling like our analysis lacks credibility and we give up. Amid the onslaught of dominant forces, we must be prepared for hegemonic contests from power structures while being clear and honest about our own standpoints and positions. We must be vigilant about the obvious and subtle ways in which white racial frames and white fragility suppress the creation of knowledge. We must be concerned not only with how we treat the voices of people of color and our white participants, but also how we treat our own voices, interpretations, and assertions- our voices that have historically been silenced and continue to be silenced, questioned, dismissed, and suppressed in the academy and elsewhere. This kind of ideological and political transparency in research are necessary for "coming clean" at the Self-Other hyphen. I had a telling moment one semester after all the careful revisions and rewrites on the book were done. One of my students who had earlier identified as politically conservative said: "There are a lot of facts and information presented in the book and a lot of stories, but I still disagree." I smiled because we had now both achieved ideological and political transparency.

In the end, the Self and Other are indeed "knottily entangled" in the research process and troubling these knots is an ongoing process of working the hyphen for all researchers. As an Indian immigrant from the global south, my story is quite different from that of an indigenous woman or a Black man in the United States. There is a vast difference in how we live in the world and how we are received by the world, yet when Xavier leaned back in his chair and said "*now I can feel a little comfortable*" our worlds joined. I intentionally use the phrase "person of color" to signal my solidarity with Xavier and participants of color and to acknowledge our shared experiences of racism, colonialism, exclusion, microagressions, hypervisibility, and invisibility. As a researcher, I use the tools that I have to join in social struggles with those who have been subjugated because like Xavier I know what it means to be uncomfortable and what it means to feel "at home." I know what it means to be vigilant and what it means to lean back in the chair. I know what it means to have skin that is always suspicious. I cannot write *about* the Other, because I am the Other. But this entanglement makes navigating the hyphen grueling labor- the labor of writing with "theoretical rigor and political savvy" (Fine et al., 2003, p. 199), the labor of writing with ideological transparency, the labor of writing with passion and compassion, the labor of always remembering the voices and bodies that have been forgotten, the labor of comprehending and responding to white fragility, and the labor of battling hegemonic forces that simply prefer the way things are.

DATA AVAILABILITY STATEMENT

All datasets analyzed for this study are cited in the manuscript/supplementary files.

ETHICS STATEMENT

The data presented in the book Feeding the Other: Whiteness, Privilege, and Neoliberal Stigma in Food Pantries (de Souza, 2019) is from the research project titled The Food-Based Community Economy: Understanding How Community Enterprises Provide for Those Experiencing Food Scarcity, a 4-year, mixed methods project examining the various ways in which individuals who experience food insecurity provision themselves. All research protocols were approved by the Institutional Review Board of the University of Minnesota IRB Code Number 1106S01082. Consent was obtained at the individual level for each client, staff member, and volunteer interviewed.

AUTHOR CONTRIBUTIONS

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

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Critical Health Communication Method as Embodied Practice of Resistance: Culturally Centering Structural Transformation Through Struggle for Voice

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The Marxist roots of critical methodology envision method as anchor to an emancipatory politics that seeks structural transformation. Drawing on our negotiations of carrying out culture-centered health communication projects amidst neoliberal authoritarianism, we explore the nature of academic-activist-community collaborations in envisioning democratic infrastructures for socialist organizing of health. Method is thus inverted from the hegemonic structures of Whiteness that construct extractive relationships perpetuating existing and entrenched health inequities to partnerships of solidarity with subaltern communities committed to a politics of "placing the body on the line." We work through the concept of "placing the body on the line" to depict the ways in which the body of the academic, turned vulnerable and weaponized in active resistance to neocolonial/capitalist structures, disrupts the hegemonic logics of power and control that shape health within these structures. Examples of culture-centered projects at the global margins offer conceptual bases for theorizing embodied practice as resistance to state-market structures that produce health injustices. The body of the academic as a methodological site decolonizes the capitalist framework of knowledge production through its voicing of an openly resistive politics that stands in defiance to the neoliberal structures that produce health inequities. We challenge the communication literature on micro-practices of resistance, interrogating concepts such as "strategic ambiguity," "pragmatic interventionism" and "practical engagement" to offer method as embodied practice of open/public resistance, as direct antagonism to state-market structures. Through the re-working of method as embodied resistance that is explicitly socialist in its commitment to imagining health, culture-centered interventions imagine and practice Marxist advocacy and activist interventions that disrupt the intertwined hegemonic logics of capital and empire.

Keywords: culture-centered interventions, critical methodology, solidarity, structural transformation, voices, activism, resistance, campaigns

INTRODUCTION

After 6 years of creating interventions that challenged health-threatening neoliberal policies across Asia's margins, the Center for Culture-centered Approach to Research and Evaluation (CARE) moved its home out of the authoritarian context of Singapore (see Dutta interview in Today [1,2]). This movement tells the story of complex negotiations of the body, the body of the academic and the body of a collective committed to building infrastructures for subaltern voices, constituted amidst the authoritarian workings of institutional, bureaucratic, and state power. In performing our labor as academics building communicative infrastructures for subaltern voices (Dutta, 2018), we were subjected to pressures, techniques of silencing, tools of disciplining, and pathways of co-optation from various arms of the system[3]. These pressures, experienced as interrogations, meetings, questions, and directives to change the courses of culture-centered interventions as they emerged through the presence of subaltern voices, materialized on our collective body. Our practices were turned into subjects of scrutiny, accused of irregularities as they sought to imagine health as a human right. For instance, one of us was accused in an audit of hiring activists in human rights, not health communication. As the Center continued/s its work in Singapore, China, and in increasingly authoritarian contexts (such as India where activists-academics are killed in broad daylight for challenging the fascist Hindutva forces), various partnerships with communities and community organizers, civil society groups, and activists enable the ongoing work of co-creating communicative infrastructures for subaltern voices. These relationships offer anchors for sustaining our embodied resistance, with ever-expanding forms of state scrutiny and repression in the service of global capital.

The body manifests the effects of state control, expressed in symptoms such as fainting, throwing up, experiencing waves of shiver, and running high temperatures[4]. These embodied effects, folded into intimate and familial spaces of affect, reflect the negotiations of everyday anxieties and stress constituted in the struggles to co-create subaltern voice infrastructures. At cognitive and affective levels, the presence of the body in solidarity with subaltern struggles for voice disrupts the state's neoliberal governmentality. Health and well-being emerge as the sites of struggles for subaltern voice, inverting the neoliberal ideology of health communication that constrains the role of communication to individual-level interactions and state-driven individualized campaigns of behavior change (Dutta, 2005). Moreover, the state's rhetoric of engaged/participatory governmentality as a model of smart governance (Kong and Woods, 2018) is disrupted by accounts of erasures of voice, participation and articulation emerging from the subaltern margins. At the material level, the presence of the academic as activist in solidarity with subaltern struggles disrupts the organizing of knowledge within hegemonic structures (Dutta, 2019a,b).

The Marxist[5] roots of critical methodology envision method as an anchor to an emancipatory politics that seeks structural transformation through collectivized formations of the dispossessed (Freire, 1973; Wright, 1993; Horkheimer and Adorno, 2002). This turn toward emancipation through work with margins anchors the culture-centered approach (CCA hereafter), embedded in an acknowledgment of exploitation and emancipation as universal phenomena, re-worked through the specifics of context as a localized site of agentic struggle (Dutta, 2008, 2011, 2015). The process of cultural-centering therefore is one of co-creating communicating infrastructures through solidarities with the subaltern margins. The three key methodological tools of the CCA, voice, reflexivity, and structural transformation (Dutta and Basu, 2008; Dutta, 2018) are embedded in embodiment, the physical placing of the body of the academic amid the subaltern struggles for voice. Voice, and more specifically subaltern voice, emerges within this struggle as the site of articulation and structural transformation (Dutta, 2004a,b). While the interrogation of the politics embodied in hegemonic texts can offer an entry point into struggles for counter-hegemonic formations (Lupton, 1994; Dutta, 2005), we argue that such textual analysis of hegemony is only (can only be) a starting point for culture-centered interventions into health communication (Zoller and Dutta, 2009), with the actual work of structural transformation realized through questions of what it takes to co-create infrastructures for subaltern voices. Beyond the works of pedagogy in the classroom and publication of findings in largely inaccessible journal articles or books, cultural centering is an invitation to placing the body of the academic in solidarity with subaltern struggles in the public arena.

Noting the thorough co-option of culture and critique within the neoliberal formations of neoliberal academia, with the privileged postcolonial academic working within the structure of capital (Dirlik, 1994; Ahmad, 1995), we explore the turn to culture in the CCA as a call toward an active politics of living a critical life (Ahmed, 2017), embodied in continual suspicion toward hegemonic structures through the placing of the body, our body/ies, in acts of resistance to state-market structures and in solidarity with the subaltern margins (Dutta and Basu,

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[1] https://culture-centered.blogspot.com/2019/10/are-culture-centered-projects-viable-in.html

[2] https://www.todayonline.com/singapore/head-nus-communications-faculty-quits-join-new-zealand-university

[3] Even as we voice these challenges, we recognize the contingency of these articulations amid potential threats of lawsuits, techniques of disciplining, and targeted campaigns. The newly introduced Protection of Online Falsehoods and Manipulation Act (POFMA) poses significant challenges of freedom of expression broadly and academic freedom specifically. One of us, Mohan Dutta, organized as part of a collective of academics, challenging POFMA.

[4] How much we share, how we share, and how we voice our bodily struggles is constrained by the authoritarian structure of Singapore and the ways in which it scripts techniques of control over the body and its expressions of voice.

[5] The concept of Marxism itself takes a peculiar turn in the context of Singapore, where the pro-colonial history of Singapore and the collaboration of the ruling People's Action Party (PAP) with the British rulers to fight Communism forms the bulwark of the national propaganda. In this backdrop, in 1987, civil society workers were labeled as Marxist conspirators and subjected to the draconian internal securities act (Barr, 2010). The narrative of the "Marxist conspiracy" works as a cautionary reminder of the risks attached to declaring Marxist attachments in Singapore.

2013; Bradford and Dutta, 2018). This critical reading forms the basis for the ongoing interrogation of the politics our bodies inhabit. Cultural centering as a methodology for building voice infrastructures for the subaltern margins is therefore also about de-centering the hegemonic formations that deploy culture to erase voices. It is in this labor of placing the body amid subaltern struggles of voice that theoretical lessons for communication emerge in the context of transforming the structures that constitute health inequalities. Based on a critique that the ideologies of the "structural determinants of health" approach, and the individualistic health disparities approach, leave the neoliberal structure intact, with health communication interventions focusing on individualized behavior change (albeit with a nod to structure and incorporation of culture into message tailoring), we suggest that the challenge for critical methodologies of health is one of working out the politics of how to "actually dismantle structures" (Dutta, 2016) that threaten health and well-being of subaltern communities.

Embodiment, as the placing of the body amid the struggle for voice forms the contingent, dynamic, and collectivized basis for cultural centering [see for instance our collaboration with foreign domestic workers in Singapore, in Dutta et al. (2018)]. The work of the critical method is one of embodied struggle, located in carving out a politics of solidarity with the subaltern. While on one hand, we draw our inspiration from the question of the (im)possibility of the representation of subaltern voices in neocolonial and neoliberal structures (Spivak, 2005), on the other hand, we locate our bodies amidst struggles seeking to build voice infrastructures that imagine structural transformations through an explicitly activist politics (Dutta et al., 2014; Dutta, 2018). In this manuscript, based on four case studies, three located in the neoliberal authoritarian regime of Singapore, and the fourth located amid the ongoing turn toward authoritarianism in neoliberal India, we articulate the salience of embodiment as the basis for returning to the critical in critical health communication. The centrality of voice as the basis of structural transformation speaks to the communicative anchor of embodied critical method.

We understand the work of placing our bodies in solidarity with struggles for communicative equality as embodiment, where critique itself is the praxis of resisting structures, materializing in academic-activist-community collaborations that envision democratic infrastructures for socialist organizing of health. Culture-centered work therefore is also the work of solidarity with activists and human rights advocates that seek to build radical democracies rooted in communicative equality (see for instance Dutta, 2019a). Method is thus inverted from the hegemonic structures of Whiteness that construct extractive relationships perpetuating existing and entrenched health inequalities through individualizing frames to partnerships of solidarity committed to a politics of "placing the body on the line." Authenticity as the basis of embodied health communication method turns the critical gaze on our own bodies, offering a framework for interrogating the decisions we make in our everyday work of co-creating voice infrastructures. We work through the concept of the "body on the line" to depict the ways in which the body of the academic is turned vulnerable and is weaponized in active resistance to colonizing/capitalist structures, disrupting the hegemonic logics of power and control that shape health within capitalist-colonial structures.

The body of the academic placed on the line in solidarity with subaltern struggles for voice forms the basis of the methodology of resistance. It decolonizes the capitalist framework of knowledge production through its voicing of an openly resistive public politics that stands in defiance. We challenge the communication literature on micro-practices of resistance, "strategic ambiguity" (Johansen, 2018), "pragmatic interventionism" and "practical engagement" (Koh et al., 2017) to offer method as embodied practice of public resistance to power, as antagonism to state-market structures of power and control. Through the re-working of method as embodied resistance that is explicitly socialist in its commitment to imagining health and democratic in its articulation of opportunities for voice, culture-centered interventions imagine and practice advocacy and activist interventions that disrupt the hegemonic logics of capital and empire.

CULTURALLY-CENTERING HEALTH

The culture-centered approach (CCA) conceptualizes inequalities in health outcomes as reflections of broader structural inequalities, situating these inequalities in relationship with communicative inequalities (Guha, 1999; Dutta, 2008). The theorization of communicative inequalities in the CCA interrogates the hegemonic concept of communication inequalities as inequalities in distribution of a communication object/channel, such as a mass medium, in a society (Dutta, 2016). Noting that the dominant framework of communicative inequalities in mainstream communication theory reflects the capitalist and colonialist role of communication as an instrument for disseminating the techniques/technologies of the market across the globe, the CCA inverts the concept of communication inequalities by exploring the distributions of opportunities for voices. Drawing from Subaltern Studies theory (Dutta, 2008), it argues that subalternity, as the condition of being erased from dominant discursive spaces, is produced through the erasure of the subaltern from spaces/sites/infrastructures of voicing. The methodology of the CCA therefore seeks to co-create infrastructures for voices from the margins in partnership with subaltern communities located at the margins. The "right to voice" translates into communication interventions that seek to democratize the sites of articulation of health and well-being. We outline the following key characters of the critical method in the CCA that constitute embodied practice, in each case depicting the roles negotiated by the academic engaged in the struggles for subaltern voices to be heard through partnerships with subaltern communities.

Commitment

Commitment, the dedication to a cause, translates in the CCA as a dedication to "learning to learn from below" (Spivak, 2005). The emergence of subaltern voices into the hegemonic mainstream disrupts hegemonic articulations, usually resulting in structures responding through co-option or through threats of violence to silence subaltern voices. Embodied practice is therefore anchored in commitment, forming the basis of transformative interventions in the face of structural/systemic attacks on culture-centered interventions. We note that the structural transformations that are at the heart of achieving health are attained through collective struggles for voice. Commitment therefore forms the very basis of the ongoing struggle to locate health communication research in creating, catalyzing, and collaborating with movements of structural transformation grounded in subaltern voices. Resistance, understood as collective processes of organizing to transform unhealthy structures, begins with the commitment of the research method to listen to subaltern voices that disrupt hegemony (Bobel and Kwan, 2011). Noting the careerist opportunism that inundates contemporary academe, especially in terms of making claims to activism to serve narrow opportunistic, individualistic, or institutionalizing goals [see for instance the discussion on activism as institutionalization by Morris and Hjort (2012)], we emphasize the critical need for demonstrating commitment through the public placing of the academic body in solidarity with subaltern voices, activists, and other academics under attack by the state-market nexus (covered next).

The "No Singaporeans left behind" (NSLB henceforth) campaign (a project on poverty and health inequalities designed by the poor) emerged as an advocacy intervention designed by household members living in poverty in Singapore. The advisory group of low-income families wanted to foreground the everyday experiences of poverty, seeking to open a conversation on poverty in Singapore. They felt that the experiences of health as inaccess are constituted in the erasure of their voices and in the strategic erasure of poverty from discursive projections of Singapore (see Tan et al., 2017). The state's projection of an image of efficient governmentality and its legitimization of authoritarian governance are achieved through its narrative of managerial technologies that ensure minimum standards of livelihood for all its citizens.

Equipped with the findings of a year-long study of the relationships between poverty and health, our research team met with bureaucrats of Ministry X[6]. The bureaucrats responded to our initial findings on food insecurity and experiences of poverty by stating that food insecurity doesn't really apply to the context of Singapore. As an aftermath of the meeting with the bureaucrats, we were asked several questions by a university bureaucrat Y[7] over email, inquiring about the advocacy campaign that was to be subsequently launched. The concern expressed was that the research is political, that running a campaign is political, seen therefore as being beyond the realm of academic work. One of us, the project director, explained through the exchange how the dominant health communication scholarship is formed on the development and deployment of campaigns. It is just that the nature of the health campaign itself becomes different when the poor set the terms of the conversation as opposed to the state or private foundations setting the goals and objectives. Rather than telling themselves how to eat healthy and exercise (the traditional forms of campaigns which are widely accepted and have strong academic/state presence in Singapore, the nation itself being called the campaign nation), the advisory group members in our campaign decided to invert the messaging, instead targeting policymakers and other Singaporeans with the objective of opening up a conversation on poverty. They hope that through this conversation, communicative infrastructures will be built for challenging the neoliberal policies that sustain deep inequalities in Singapore and threaten the health of Singaporeans living in poverty. For our advisory board, the campaign became the basis for making the hidden visible.

When faced with the question, whether to stick to the campaign and its basic message or to "give in" to the diktats of the system/structure, the principle of commitment rooted us. The commitment to listening to subaltern voices and to the control over decision-making in the hands of community participants translated into sustaining the campaign in spite of the pressures and to placing our bodies "on the line" to make sure that the key messages of the campaign were not co-opted. When specific requests for change emerged from the structure, we turned to the advisory group of community members for those decisions, at the same time placing our bodies in the negotiation of the structural pressures. Whereas, the campaign slogan was modified through this process of negotiation, based on decisions made by the advisory group of subaltern community members, the body of the campaign (the narratives, the media channels selected, including placing advertisements in the state-owned media) remained intact. To commit therefore is positioned in contrast to pragmatism, the considered adoption of strategies to adopt to the diktats of dominant authoritarian structures (see for instance Oswin, 2014 critique of pragmatism in the context of neoliberal Singapore). This placing of the body on the line opened up ongoing pressures on the academic body through various forms of surveillance and ongoing interrogations directed at our bodies and at the bodily integrity of CARE by the system.

Solidarity

The CCA calls for (a) co-creating communicative infrastructures for voices of subaltern communities, and for (b) building activist and advocacy interventions that challenge structures. The process of change is embedded in solidarity, in meaningful and tangible partnerships with the subaltern margins, in walking alongside the margins, in friendships that seek change. The work of solidarity transforms into "being there" in the midst of the struggles for structural transformation, in seeding movements, in generating activist threads, in collaborating with movements, and in seeking change anchors with political parties with socialist commitments. Moreover, the work of solidarity is embodied im supporting other academics at risk for their interrogations of structures. That transforming structures elsewhere is intrinsically tied to transforming the structures within Universities is a vital lesson for solidarity.

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[6] We have anonymized the identities of the specific Ministries and other involved actors as strategic tools to protect ourselves from being sued, particularly so in the context of Singapore's new draconian law, Protection from online falsehoods (POFMA).

[7] Y is a University administrator, whose identity here has been anonymized.

For our culture-centered interventions, in the aftermath of the NSLB campaign, as the systemic pressures on our collective work increased, we experienced the absence of solidarity with our bodies. As we witnessed the various tactics deployed by the structures, the typical academic advice from radical-sounding academics within the system was to be strategic. Here, the advice on strategy meant changing the public commitment articulated earlier. With various strategies of control in place, our collective work quickly was labeled as "making trouble." One senior cultural studies academic advised, "Do the poverty work of CARE elsewhere, not just in Singapore." Another brown postcolonial academic noted, pointing to Stuart Hall, that it's all about the politics of strategic ambiguity and impure politics. This colleague didn't utter a word when she/he witnessed the various techniques deployed on our bodies by the system. Instead, she/he went on to circulate many of the manufactured communicative inversions to cast doubt on the ethics of our embodied work. Another senior cultural studies academic shared over wine stories about how Chinese men in powerful structures have to be negotiated through strategic acts of "saving face," regaling us with stories of wearing red suits. Solidarity, as we see through the lens of these experiences, when it comes to counting who stands by you amid the confrontation with structures, is liminal, quick to disappear amidst the tall claims of radicality. Yet, where solidarity is sustained, is in the everyday practices of non-academic and academic staff (mostly junior staff), who call out injustice and stand up against oppression when they witness it. For a number of us and a number of the non-academic staff, the performance of solidarity inside of academe and outside of it, with the subaltern margins and with other academics/activists resisting the authoritarian structure, turned into paying the price with our/their jobs. For some of us, this translated into quitting academia entirely.

This notion of solidarity as action is constituted in opposition to the notion of solidarity as rhetorical performance, claims, or posturing. Solidarity as everyday practice emerges within academia often at very sites of non-academic and precarious academic labor, sites that are not often given to making academic careers out of claims to radicality. What became evident in these negotiations is the powerful role of solidarity for the work of the CCA demonstrated by many non-academic and academic staff through their everyday actions and commitments, in the positions of voice they stood behind and in the truth claims they anchored themselves in amid the strategic reproduction of communicative inversions. In the work of CARE, with the recognition that the critical struggle for voices amidst the margins must translate into critical struggles for voices embodied by other academic-activists, one of us, Mohan, took public stances (often being the only senior academic in the institution to take these stances) in solidarity with the academic Pingtjin Thum when he was targeted for interrogating the state's narrative and later blacklisted from participating in academia. This also meant standing in solidarity with activists such as Jolovan Wham and Seelan Palay as they challenged the state's draconian laws restricting freedom of expression and freedom of assembly (see Dutta, 2019a,b). Mohan was interrogated for his allyship with Wham, asked questions about his collaboration with Wham as well as his invitation to Wham to appear on CARE platforms. Solidarity here is the public placing of the body in support for dissenting voices, in visible spaces that are otherwise marked as inaccessible to dissenters, and in making visible the academic value of dissenting voices (especially as these voices are actively projected as un-academic, as having no space within academia). In response to the cancellation of a program on "Dialogue and Dissent" at Yale-NUS College in Singapore, Singapore's Minister of Education delivered a speech in Parliament naming Wham and Palay, stating, "Academic freedom cannot be carte blanche for anyone to misuse an academic institution for political advocacy, for this would undermine the institution's academic standards and public standing." Mohan responded publicly to this statement, writing blog pieces, opinion pieces, and giving interviews to media.

The CCA critically interrogates academic posturing and claims to radical position that fail to show solidarity in struggles against structure, keep their bodies intact, or even worse, collaborate with structures to institutionalize their so-called radical positions (see for instance Morris and Hjort, 2012). Framing activism as a form of instrumentalism, the collection edited by Morris and Hjort (2012) depicts academic-activism as a strategy for institutionalizing cultural studies in the academe. Activism, depicted in the logic of "institutional action," serves to institutionalize cultural studies. Drawing on our experiences in dismantling structures, we note that any form of institutionalization can not be the goal of a critical project. Critical theory and methodology, anchored in a commitment to disrupting structures, ought to be fundamentally suspicious of structures, and the accompanying claims to pragmatism, functionalism, and institutionalization. As a communicative inversion, for Morris and Hjort (2012), academic-activism is molded in a narrative of pragmatism that works within institutional structures to further the hegemony of the institution, located within the hegemonic networks of institutional power. Solidarity is depicted in this section, is an antidote to such pragmatic performance of radicalism that "communicatively inverts" activism to accommodate power for institutionalizing careerist trajectories of areas, groups, and individuals.

Authenticity

The "Respect our Rights" campaign, created by foreign domestic workers in Singapore, brought in domestic workers into the spaces of decision-making in the university, in civil society, and in policy spaces, from which they have historically been absent. Many of our advisory group meetings, creative workshops, and production work were being held in the University. In many such instances, the presence of the domestic worker body in the University, an elite structure, disrupted the normative expectations of the structure, leading to academics making comments such as "What are these doing here?" Hearing these comments foregrounded the question of our location in academe, interrogating the meaning of authenticity within academic spaces.

The negotiation of authenticity, tied to the question of the identities we perform in the University, is fraught with tensions that are made evident in culture-centered collaborations. Presence of foreign domestic workers in the spaces of the university for instance, disrupt the norms of the hegemonic structures of the university. As these norms are disrupted, the authenticity of our own position is brought to question. Authenticity emerges from the recognition that the radical position in the neoliberal academe has been turned into a seduction for the market (Dutta and Basu, 2018). The experiences of our bodies individually and collective often drew attention to the powerful dilemmas we had to negotiate, with our own privileges within the academe. On one hand, the projects of CARE decorate brochures and websites, tied into claims of social impact and sustainable development goals (SDGs). On the other hand, our everyday work at CARE is constantly subjected to scrutiny and pressures.

From critical performance to the branding of social justice as promotions of the neoliberal university, "communicative inversions" keep intact the status quo. Critical health communication, captured within this tendency, is rendered apolitical, disconnected from the politics of change being fought everyday in the University, in the communities surrounding the University, and in the funded change projects. The thorough co-optation of the critical position within neoliberal university structures calls for an active politics of authenticity that turns the critical lens on the self and its commitments. Through authenticity, being true to self, critical health communication methodology turns the lens on the academic, her/his complicity in knowledge production, and the role of embodiment as a way of connecting to struggles for transforming structures that threaten health.

PRACTICAL INTERVENTIONS AS RESISTANCE

In this section, we offer examples of practical interventions as embodied methodology of resistance, depicting how the concepts of commitment, solidarity and authenticity play out in these interventions. Working through specific instances of culture-centered interventions built on solidarity with the oppressed, we bring out key concepts of embodied methodology as critique. The nature of critique, we hope to demonstrate through these examples is located in the body of the researcher placed in the middle of the struggle for voice. Cultural centering, as a method for co-creating communicative infrastructures for the voices of the subaltern, is an active politics of the body in crafting counter-hegemonies amid hegemonic formations that actively work to erase subaltern voice. In this sense, we begin with the identification that subalternity as the act of erasure, works specifically through processes, forms, techniques, and strategies that work to erase the subaltern voice. The condition of subalternity is produced because the subaltern voice is unheard, because the dominant social, political, and economic structures work to un-hear the subaltern voice. The work of cultural centering then is about building active solidarities with subaltern communities on grammars of voice and advocacy so the subaltern voice of heard. In the methodology of embodiment adopted in the context of the CCA, the question of solidarity guides the choices made by academics. Working through power and interrogating its workings, the practical interventions shared in this section work actively through collective processes to disrupt it, to interrogate and transform the hegemonic narratives circulated in the structures that violently erase subaltern voices.

"No Singaporeans Left Behind" and Embodied Resistance

Cultural theorists have long asserted that social relations of power produce bodies that are disciplined and resistant (Foucault, 1995). Embodied resistance provides a framework in understanding the everyday lives of those who violate socially constructed social rules and conventions (Bobel and Kwan, 2011). It is through this lens then, embodied resistance is viewed within "oppositional action" that challenge contextual norms that is rendered in many forms (Hollander and Einwohner, 2004). Such has been the case of the NLSB campaign in Singapore, where poverty is considered an 'Out of bound" (OB) markers. The silence around poverty in Singapore translates into the absence of discourses on poverty when this project started in 2012, and the systematic erasure of the voices of the poor from the discursive space. The poor emerge in state-controlled discourses as low-income recipients of welfare, with policy, expert, and civil society discourses debating on the appropriateness of support for the low-income. Hegemonic discursive constructions reproduce the narrative of welfare-dependent, lazy poor to uphold the state-crafted neoliberal ideology of smart human capital as the basis for Singapore's progress.

In April 2016, the Center for Culture-Centered Approach to Research and Evaluation (CARE) at the National University of Singapore launched an online campaign to raise awareness on poverty in Singapore, built by an advisory group of community members living in poverty. The campaign, titled "No Singaporeans Left Behind," was the first campaign in Singapore driven by individuals who were living in poverty, based on research they guided, storyboards they created and owned, and communication strategies they designed. The campaign was conceptualized and designed by an advisory committee comprising 10 men and women who were from the low-income community in Singapore. Over the course of seven months and six regular meetings, the advisory committee came together to identify the key issues affecting the low-income in Singapore, brainstormed possible solutions and interventions to raise public awareness, and directed the design and production of the entire campaign. This process was informed by a multi-team ethnography comprising over 250 h of participant observations, and 200 in-depth interviews, anchored in decisions and guidance offered by the advisory board. Advisory members participated in making sense of the emergent data, thus guiding the white paper that would form the infrastructure of the campaign.

Ownership of the decision-making infrastructures in the hands of community members meant that the process itself was an inversion of the authoritative model of managing low-income households. The 30 days-campaign materials included a print advertisement, a 1-min video advertisement screened online, a dedicated website, with links to the White Paper, social media pages on Facebook and Instagram, and a 30-min documentary. As part of the campaign plan, two workshops focusing on key topics such as financial assistance, aging issues were organized to bring together advisory board members practitioners, NGOs, and academicians. Various bodies of the state were invited to the conversation, but did not participate in them because of the narrative control held by advisory group members. The workshops themselves emerged as transformative sites, inverting the dominant method of conducting engagement and dialogue driven by the state. The workshops also embodied confrontations in their public design; the advisory group wanted the workshops to be public so the discussions with various officials could be open to anyone. When we met with bureaucrats in the state structure with the invitation to the workshop, we were met with sermons on how the definition of "food insecurity" depends on context and that language such as "Voices of the poor" doesn't work in the context of Singapore. One such meeting also initiated an entire cycle of surveillance of the NSLB campaign and the broader work of CARE.

The NSLB campaign materials function as a counter-narrative to the mainstream discourse articulated by the state. The perspective of "resistors" is interrogated viz-a viz the socio-cultural relations that act on individual bodies. Singapore is a city-state, dubbed one of the four Asian Tigers in the region. The high-economic growth coupled with rapid industrialization and exports have facilitated the city-state to be in line with the wealthiest nations. Thus, there are pervasive and conscious efforts to project Singapore as an exemplar city-state, and Singaporeans as worthy of being considered world-class and cosmopolitan. Against this global imaginary, narratives of poverty are restrained from the public sphere.

The campaign sets out to disrupt the notion of "happy, urban dwellers" and invoke an alternative urban futurity through embodied resistance. The voices and stories serve as powerful resistance identity that disrupts monolithic frames of the poor, often viewed as lazy, unwilling to work, and therefore making poor life decisions. In particular, the 30-min documentary primarily features interviews with low-income individuals sharing their experiences with poverty and with receiving help. The struggles are highlighted through the painful awareness of poverty as embodied presence in Singapore. The wide coverage of the campaign in mainstream media, resulting in over 13 stories, and a newspaper issue dedicated to poverty disrupted the erasure. Voices of participants, positioned as interpreters of poverty circulated through news stories and digital narratives, anchored the conversation on poverty in Singapore.

As noted earlier, the NSLB campaign tested the commitment of the research team, embodying various forms of risks throughout the cycle of the campaign. From facing specific directives regarding the campaign to being interrogated for it, we negotiated the structural impediments to voice through commitment. Whereas, pragmatism might guide us to be strategic as we were told to "study poverty somewhere else," commitment meant sticking to the course. Whereas, pragmatism might have guided us toward giving up on the public campaign and seek "closed door meetings to share our findings" as we were often instructed to do, commitment translated into staying with the objectives of the project in building communicative infrastructures. The interplay of solidarity and commitment rested on authenticity, as we continually asked as a research team what our values are, what does it mean to embody these values, and what does it mean for erased subaltern voices to be heard.

"Respect Our Rights" and Disruptive Narratives

The "Respect our Rights" is a campaign for domestic workers by domestic workers in Singapore. The campaign adopted the theoretical frameworks of the culture-centered approach and the process of radical participatory communication practices in constructing communicative techniques that sought to disrupt the hegemonic narrative of domestic work. The hegemonic narrative that dominates the discourse on migrant domestic work in the cosmopole is entrenched in the idea that the transnational flow of labor creates sustainable employment opportunities for those residing in the peripheries of global capital (Dutta and Kaur-Gill, 2018). Such ideological hegemons debar and silence narratives that inform the plight of the subaltern migrant worker (Bernardino-Costa, 2011) residing in the margins of the cosmopole.

The "Respect our Rights" campaign was targeted at disrupting the status quo discourse that peripheral migrant workers exist in dignity in these global city centers. Adopting Singapore as a case study, domestic workers residing here face key structural disadvantages that infringe on their labor, human, and health rights (Dutta et al., 2018). The nature of the hire of migrant domestic workers locally creates replete opportunities for abuse (Huang and Yeoh, 2007). In detailing the key narrative of the "Respect our Rights" campaign through participatory openings, domestic workers highlighted health rights as violated when their contracts were not obligated by employers. Their voices disrupted the dominant position that most migrant domestic workers were "satisfied with their work conditions" (Ministry of Manpower, 2015, p. 3) and structural processes were in place in protecting the rights of workers (Channel News Asia, 2017). Structural actors in the context of domestic work refer to gaps in the system that allow for the exploitation of domestic workers.

A key actor includes an errant agent that partakes in contract substitution during hire and post-hire. These agents may also typically deprive key communicative infrastructures to workers, such as not providing them with information about their labor rights, not translating or reading the contract to the domestic worker during hire, and failing to provide helpline services such as the contact details of the Ministry of Manpower Singapore, an emergency hotline or a local non-governmental organization contact in situations of distress. At a policy level, workers are not covered in the local employment act, thus limiting opportunities for due process in situations of mismanagement by employers. These gaps leave workers vulnerable to exploitative circumstances.

In conducting formative research, a key strategy of the "Respect our Rights" campaign was in positioning disruptive narratives that created spaces for alternative discourse on migrant worker rights to emerge. Workers highlighted how their health rights were tied to their human and labor rights as workers. These narratives were thematized systematically by workers and researchers before documenting them in the form of short television advertisements and newspaper advertisements. The media material created for the campaign highlighted the conditions of domestic work that could entail a lack of sleep from overwork, little access to sufficient food, contract substitution, physical, verbal and sometimes, sexual abuse, and receiving incorrect or no wages for their work. These storied realities centered on the key message of the campaign to local employers to respect the basic rights of domestic workers (Dutta and Kaur, 2016).

The configuring of the disruptive message was just as salient as the channels highlighted to distribute these messages. Our participants identified the key target audience as employers and strategically inquired into the kinds of channels local employers engaged in. "Respect our Rights" media material were then distributed along these channels as an intervention strategy. Between 2013 and 2018, the "Respect Our Rights" campaign already had three iterations, all with different embodiments of risk. The advisory board for the third round of the campaign was made up mostly of Burmese domestic workers who, arguably, are the most marginalized among the domestic workers, mostly because of linguistic and cultural differences, because of the age at which they arrive in Singapore, and because of the high likelihood of trafficking. They voiced out how they wanted to be treated as humans, just like everybody else, articulating stories of abuse. For this iteration, they wanted to communicate with fellow Burmese domestic workers as they felt that many of their peers are unaware of their human rights and have no way to find out about their rights, as well as speak about atrocities they experience to the "general Singapore public." A few meetings and other FDW nationals filtered out, and what was left was an all-Burmese advisory board, with the conversations held in Burmese with the support of a bilingual community researcher. They felt strongly about the message of human rights; they also wanted to use social media and face-to-face peer campaigning.

The domestic workers brainstormed the content and the CARE team went back and forth with the materials with them. After the FDWs created, edited, and finalized the campaign collaterals, the partner organization (a local NGO in Singapore that does migrant worker advocacy) did not like it, because a new board felt the campaign was too bold and "on your face." It was a major setback and one that went through deep discussion within the team whether to push through with the campaign or not. In the end, the team worked with the advisory board of domestic workers, staying faithful to the voices of the Burmese FDWs and what they wanted to communicate. This round of the campaign had the highest engagement amongst the materials produced by the team. Majority of those who interacted are FDWs from various nationalities. Many shared how the videos resonated with their lived experiences, and voiced their stories. Committing to sustaining the voice infrastructures meant that the campaign continued in spite of the withdrawal of the NGO partner. Authenticity as a methodological anchor meant that the voice infrastructures were accountable to the meanings held by subaltern Burmese domestic workers. This is critical in the context of Singapore where authoritarian state control translates into a civil society that serves as a mediator, often negotiating with the state through undemocratic behind-closed-doors negotiations anchored in "saving face." In an elite culture where "saving face" among the elite translates into the censorship of civil society articulations along aesthetic guidelines palatable to the state and where worker protections are secured by the elite through closed-door negotiations, the campaign disrupted the paternalism through its commitment to communicative equality. Authenticity formed the basis of the solidarity with the subaltern advisory board members, which in turn, served as the basis for embodied actions, building networks of interventions created by FDWs.

The "Respect our Rights" campaign remains a key intervention that adopted culture-centered participatory strategies to support the crux of designing culture-centered campaigns, where agentic possibilities are realized by disenfranchised communities through their ownership of decision-making processes. In campaign design, the centering of community voice in every step of the decision-making process forms the first step toward communicative equality, as the basis for ongoing subaltern struggles for voice in the discursive space. The themes of commitment, authenticity, and solidarity play out throughout the various structures, spaces, and processes of decision-making, fundamentally dismantling the communicative inequalities that form the discursive infrastructures around domestic work. Commitment constitutes the architecture of the intervention that disrupts the structure and its curated/censored storytelling strategies, embodying health in claims to justice.

"Stiletto Project" and De-centering Structures

While there is high visibility of LGBT communities in Singapore, transgender[8] persons comprise a small, marginalized portion of the community, an even smaller proportion of which tend to go into sex work at a young age amidst various structural, socioeconomic and cultural factors. The health of transgender sex workers (TSWs) in Singapore is overlooked, misunderstood and erased by health structures, where there is little to no participation in health policies and processes. Singapore's health authorities, the Ministry of Health and its statutory board, Health Promotion Board, take an approach that simultaneously medicalizes and erases the TSW community in its identification and categorization as 'Men Having Sex with Men' or MSM, a population defined by its vulnerability to sexually transmitted infections such as HIV/AIDS, amongst others. The stigmas and intertwined structural violence constitute the everyday negotiations of sex work amid an authoritarian structure that continues to criminalize sex outside of strict heteronormative

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[8] We use transgender as an umbrella term for persons who challenge gender normativity, which includes persons who identify as transfeminine, transmasculine, transsexual, hijra, genderqueer, female-to-male (FTM), male-to-female (MTF), intersex and more. In general, transgender refers to someone whose gender differs from that assigned at birth.

forms. In this backdrop of the erasure of the voices of TSWs, our culture-centered collaboration sought to build a communicative infrastructures where TSWs articulate, implement, and circulate a research agenda, constituted specifically in the context of advocacy. Our ethnographic collaboration with TSWs organized under the umbrella of Project X resulted in a collaborative research project, communication intervention, advocacy campaign addressing stigma, a white paper, and a digital infrastructure owned, controlled, and run by TSWs.

Project X, a sex worker advocacy and support organization, has documented issues faced in the transgender sex worker communities with which they work, who are often of low-income status, face barriers to education, from minority ethnic groups, caregivers and breadwinners, and face discrimination and violence in their everyday lives from the police, public housing officials, healthcare professionals, members of the public, clients, intimate partners, and their own family members (Ho et al., 2015). With these vulnerabilities come exacerbated health insecurities for transgender women in Singapore. Concomitant with the impacts of global trends of transphobia, transgender sex workers in Singapore seem to be at high risk of mental health issues, where they may have ideated, attempted or completed suicide or engaged in other types of self-harm, especially those exposed to higher levels of violence, discrimination and instability, and may experience social stress or anxiety disorders such as post-traumatic stress disorder (PTSD) (Lawrence, 2007; Meyer and Northridge, 2007; Bowen and Murshid, 2016).

In collaboration with Project X, our team worked with advisory boards of 10 TSW community members, peer leaders and transgender researchers over 30 meetings to form the Stiletto Alliance, or the Stiletto Project. These meetings were aimed at brainstorming, and designing culturally centered health communication collaterals for community members focused on self-empowerment and financial security, social support including coping with stress and stigma, accessing hormone therapy and gender affirming surgeries. Inverting the hegemonic framing of HIV/AIDS as the anchor to transgender health, central to the intervention infrastructure was the addressing of structural contexts of TSW health, disseminating information among TSW to foreground the role of structures, and from this information-based solidarity, develop collective efforts at addressing the structural contexts of health such as housing, stigma, policing, access to education, and access to income representation.

In many of the advisory board meetings, the community members would articulate going strongly with the messages of the campaigns. They were also very clear with their target audiences, first is to educate and raise awareness among peers; second, to educate the public about the stigmas attached to transgender sex work. Both stages demanded immense solidarity from the team. In many stages of the project, we received questions regarding administrative decisions related to the project. For example, we faced a lot of setbacks with engaging and hiring peer leaders, giving them access to university resources, securing spaces for them, and hiring them as community researchers on our projects. In an audit, one of us was asked why CARE hired a human rights activist (referring to one of our transgender sex worker community researchers) as a community researcher.

Identifying the representation of TSWs in mainstream media and public discourse as the site of threatening TSW health, advisory group members sought to develop infrastructures for voice that explicitly addressed their erasure. They identified media advocacy as a strategy for inverting the erasure, and for creating the bases for transforming structures. The advisory group engaged in scripting, storyboarding, acting and co-directing video advertisements targeted at members of the public as well as policymakers through digital spaces such as Facebook and Youtube. The advisory board members focused their ideas on three themes: police harassment of transgender sex workers, discrimination against transgender sex workers in public, and transgender rights. Through a deliberative decision-making process, they developed the "Adapt. Accept. Respect" Campaign, with the messages (a) "If you don't discriminate against race and religion, don't discriminate against transgenders."; (b) "We are transgenders"; (c) "We are human." These messages worked to call the public to change their attitudes toward transgenders, and recognize the not-so-radical notion that transgender people were human too. The second message recalled Singapore's national pledge, "We, the citizens of Singapore,/pledge ourselves as one united people,/regardless of race, language or religion," adding transgender to this appeal to mainstream national and cultural values of equality for all citizens.

They interweave the language of minority rights with the language of neoliberal citizenship, and pose the question of deservedness: if transgender sex workers are hardworking, tax paying Singaporeans too, should they not deserve equal recognition? One video forewarned of the significant impacts of such stigma and discrimination against TSWs in Singapore and Malaysia: low self-esteem, depression, suicide, public violence, and even death; the other celebrated transgender sex workers as strong, proud and standing in power. What is critical to the intervention is its disruption of the state-sponsored structures imposed on representation of TSWs. Despite barriers to engaging in a national television commercial campaign (the Infocomm Media Development Authority in Singapore restricts "[f]ilms that…promote or justify a homosexual lifestyle"), the videos were released on digital platforms (Facebook and Youtube) through advertisements and a white paper, generating 245,000 views, 300 comments, and over 500 shares altogether over a 5 month period. The digital infrastructure "Stiletto Alliance," liked by 1570 followers, is owned and run by TSWs, building a sustainable basis for structurally transformative messages, depicting the themes of commitment, and authenticity articulated earlier.

Embodied critical praxis emerges in the project in actively articulating a gender rights discourse in the context of an authoritarian regime where expert scholarship has appealed to culture to precisely erase the conversation on rights. Hegemonic forms of scholarship emerging from elite spaces within Singapore point to the impossibility of a rights language, instead promoting concepts such as accommodation, illiberal pragmatism, and collaboration. The argument goes somewhat like this; the language of rights is West-centric, and what is therefore needed for social change to work in Singapore is a form of pragmatism that accommodates to Singapore's unique illiberalism. In the voices of our collaborators, this language of accommodation keeps power structures intact, failing to transform the structures and keeping power in the hands of elite ventriloquists with access to power. As noted by Chitra, one of our advisory group members who participated in designing the intervention, "Fuck anyone that says human rights language does not work in Singapore. We take the risks of speaking up knowing that these are our human rights. We don't want anyone to come and say, human rights does not work in Singapore." In our solidarity, we share and bear the risks of embodied struggles for democratic infrastructures (and are targeted for doing so, as noted in an excerpt earlier), constituted amid the various threats to speaking up amid powerful institutional, societal, and state-dictated structures of silencing.

Farmer Suicides and Public Health

Situated in the theoretical framework of the Culture-Centered Approach (CCA), this intervention deployed voices of the structurally disenfranchised farmer widows as a tool for interrogating, firstly the dominant development narrative of high-yield technology-driven agriculture, and secondly the psychosocial and psychiatric approach to mental health initiatives in the marginalized settings. The individual-centric care provided in these approaches discounts the structural inequalities experienced by the farming communities. The counseling and mental health awareness programs specifically targeting farmers in stress run by local Non-Governmental Organizations and the state government underway in Maharashtra by training human resources, aiming to prevent psycho-social distress, and management of mental health disorders by delivering community-based mental-health interventions, through projects such as VISHRAM (Vidarbha Stress and Health Program) in the Vidarbha region, Prakriti in Amaravati, and a project by Watershed Organization Trust in Wardha with technical expertise in Wardha (31 January, Pal, 2017) are offset by the narratives of the farmer widows. Disrupting hegemonic health communication narratives that parochially construct communication as messages and meanings constituted around health practices and in health settings, the overarching commitment of the project to listen to the voices of widows amid the agrarian epidemic embodies risk through its very disruption of the framing of health (as provider-patient interaction, eating five servings of fruits and vegetables, exercising, safe sex etc.) amid structures of Whiteness.

This project involved ethnographic fieldwork among the widows of farmers who have committed suicides amid the agrarian crisis unfolding in India. Voices of the farmer-widows were the central tool for interrogating the dominant development narrative of high yield, biotechnology-driven agrarian transformation that has replaced the indigenous farming systems (Rastogi and Dutta, 2015). Farmer suicides are constituted amid large debts taken by farmers from private sources for high interest rates to support the investment-intensive Bt cotton farming (Vasavi, 2012). The expensive seeds, fertilizers, pesticides are bought from the privately owned farming-inputs shops based on the advice given to the farmers by the input dealers. Yet crop failures are common in the drought prone region of Vidarbha, the eastern part of the state of Maharashtra that is mainly known for cotton production. Untimely rain or dry spells and unpredictability of changing monsoon patterns in the recent years add to the challenges that poor farmers face. In spite of the promise of the genetically modified cotton, pest attacks and crop diseases are widespread. In absence of input subsidies, guaranteed price for cotton produce that would earn the farmer a margin above the investments he made, and middlemen who buy the farmers' produce for cheap and sell for high profit margins has driven the poor farmer to indebtedness and loss of hope (Vasavi, 2012; Rastogi and Dutta, 2015).

In the backdrop of neoliberal reforms of the Indian economy that enabled the entry of transnational corporations into the Indian agriculture, replacing indigenous farming systems and commercializing agricultural input-output system, voices of the farmer-widows center the subaltern agency in foregrounding the meanings of farmer-suicides, and the stress borne by widows after the suicides. Through the voices of the widows, this project brought forth the narratives of neoliberal, patriarchal structures of agriculture that ties the respectability of the men in the households to their ability to provide for their families and pushes the male members of the family into alcoholism, gambling, and ultimately suicide by consuming pesticides or jumping into the well in their own farms. The narratives speak of extreme stress of indebtedness, worries about children's education and marriages, and feeding the family daily, while the farmlands remain dry and cotton crop fails after a whole year's labor and investment.

While suicides are committed by the male members of the farming households, the mediated discourse gives disproportionately less attention to the widows of the farmers. The narratives of the widows in this project centered the gendered subaltern who survives the death of her husband and faces the stigma of widowhood in the patriarchal rural structures. The money-lending structures exclude widowed women who are seen as having less ability than male members to repay the debts. The bureaucratic structures often remain inaccessible to the widows without a male accompaniment. The financial decisions of the household fall on the widowed woman who was earlier excluded from these decisions in patriarchal make-up of households. The extreme stress of keeping children alive, earning a livelihood for the household amid the highly laborious yet uncertain agriculture exerts stress on the widowed women who confess to having suicidal thoughts but prevent themselves from taking the step due to concern for their children.

These narratives are embedded in the cultural fabric of the rural, agrarian structures, while working collectively to offer universal anchors for structural transformation. Voice, within the CCA is embedded in the structural inequalities experienced culturally by marginalized populations (Dutta, 2008, 2011), and in the centering of subaltern agency as collective bases for change, offers collective imaginaries that disrupt neoliberal capitalist co-optation of agriculture (Thaker and Dutta, 2016). This imaginary of resistance is grounded in the actual work of generating knowledge that disrupts the knowledge claims, techno-deterministic solutions, and frameworks offered by transnational agro-capital. Our ongoing partnership with women farmers organized into cooperatives or *sanghams* under the umbrella of the Deccan Development Society (DDS) voices subaltern knowledge as the basis for universal transformation of agriculture (Dutta and Thaker, 2019). For instance, the concept of seed sovereignty emerges from the collective organizing of subaltern women, placing forth the knowledge that seeds are collective and community resources for health and well-being, owned by communities where the knowledge of growing seeds is located, and therefore, in resistance to the privatization of seeds for profit. The articulation of seed sovereignty is the basis for conceptualizing a sustainable ecosystem where food owned by communities through community-based practices is the basis for health.

The colonization of agricultural knowledge, practices, and resources of the poor farmers has transpired through joining of hands of multiple global and local elites, even producing consensus among the farmers themselves in favor of biotechnology-driven transformation in agriculture (Shah, 2005). Juxtaposed against the discourse of technology-driven agricultural development were the lived experiences of the grieving widows whose living conditions witnessed in their voices, and whose narratives of loss, hopelessness, and struggle for survival formed the basis of the listening infrastructures. These listening infrastructures disrupted our own city-swelling, upper class, upper caste bodies, located in the elite institution of knowledge building in Asia's knowledge capital. Our embodied privileges are juxtaposed in the backdrop of living conditions of perpetual hunger and indebtedness, incurred from previous farming cycles. As we witnessed the profit-making agendas of private inputs shops in Yavatmal, which also send vehicles to the surrounding villages to advertise the pesticides and other plant medicines that usurp the labor and resources of the small farmers for profit, and then act as the sources of credit for the farmers, our interrogations turned to the questions of the nature of communicative infrastructures we could co-create.

The absence of and limitations of the institutional support to the small farmers prior to and after farmer suicides was evident in the struggles that widows faced. Being situated within the structures of power that reproduce the hegemonic discourse of development in agriculture, our journey was filled with the emotional labor of listening and witnessing, foregrounding the narratives of the widows from intersections of the farming community to create spaces for narratives of failure of the dominant development model to be heard within those dominant structures. The fieldwork itself posed the challenge of being perceived as someone who perhaps works for the government or a private company, who could offer some immediate relief to the widows. This was a recurring moment of awareness about our positions within the structures of power while simultaneously struggling to foreground the cognitive legitimacy of the agrarian crisis as a health crisis. As health communication researchers, positioning suicides as fundamentally about health poses embodied risks amid the Whiteness of a discipline that parochially constructs health as individual behavior or as explicitly articulated health texts to be analyzed. Reviewers of submissions, including reviewers demonstrating commitment to the critical cultural paradigm, often noted that suicides have nothing to do with health communication, suggesting we submit our manuscript to sociology and anthropology journals. That each submission we make to health journals returns with rejections, with comments about the irrelevance of suicides and agrarian crisis to health depicts the Whiteness amid which this scholarship is placed and that it resists. The precarity one of us experiences as a junior academic is multiplied by the challenges of doing social justice work as anchor to health and communication, especially amidst the colonization of the critical health communication space by disembodied scholarship that demands abstractions.

Critical health method as embodiment here transforms into the body of the academic in solidarity with subaltern social movements imagining ecologies and farming systems that offer alternative pathways for health, healing, and wellbeing. The "doing" of agriculture as a collaborative practice that is imagined through subaltern knowledge re-works the large-scale capitalist co-optation of agriculture. The work of the Millet Network in placing millet as a sustainable crop and as the basis of health (of the human body as well as the ecosystem) works through embodied partnerships (Thaker and Dutta, 2016), with the everyday work of academics in the middle classes in interrogating academic privilege to generate knowledge claims from the global South, particularly from indigenous communities in the global South.

DISCUSSION

The call to cultural centering as a critical method is based in a commitment to global transformation. The values thus developed in culture-centered activist interventions, although specific to the local struggles that they develop in the context of, are universal in their transformative call. In fact, they deconstruct the turn to culture as evident in the cultural sensitivity approach (Dutta, 2007), depicting the ways in which culture is incorporated into hegemonic interventions to consolidate and reproduce power. The acknowledgment that meanings of health form the basis for imagining communicative infrastructures for achieving health interrogates the dominant approach to health communication that unfortunately and stubbornly so, focuses on the reductionist, individualized, and parochial framing of health (Dutta, 2005). Embodiment as critical health communication therefore we argue, forms the heart of interventions into the disciplinary, depicting the urgency for aligning our loyalties with a transformative politics that works alongside class politics, collective organizing, dissent, and subaltern resistance to neocolonial extraction.

Transforming the Discipline

Turning to subaltern communities to ask, "What does health mean to you?" as our fundamental starting point, and then working from this starting point to build health communication/advocacy/activism means that our work embodied the ongoing risk of not being publication-friendly to the hegemonic norms of health communication, including paradoxically, the domains of critical health communication colonized by textual analyses and grotesque abstractions. The struggles for subaltern voice render visible the limits to the register of the text. Subaltern voices, in their understanding of health amid structures, ecologies, capitalism, threats to human rights, implode ontological categories that disrupt the dominant assumptions that inundate the disciplined terrains of health communication in the global North (we therefore are continually challenged with the question, "What is health in this?" which is fundamentally Eurocentric in its parochial understanding of health). These voices invite us to the possibilities opened up by bodily insertions into relationships of solidarity with subaltern struggles, challenging the superficiality of extractive texts that turn solidarity into a footnote, conclusion, or textual insertion. Subaltern voices in our work, embodied in interactions and relationships, thus threaten to dismantle the body of health communication scholarship, turning our struggles into embodied resistance.

Part of our embodied resistance through the struggles for voice is the interrogation of our practices as health communication scholars (thus participating in the methods of health communication), albeit at different locations and in different positions of social, economic, and political power within the academe. In an audit, one of us was asked, "what does health have to do with human rights?" While one of us is a Full Professor, others are mid-level academics with job security, others are in precarious academic positions, yet others are junior academics seeking academic homes, and some others who have had to quit academe altogether amidst ongoing struggles. The precarity of some of our positions is tied to the explicit diktat issued by the structure to steer clear of social change communication and in other instances, to cleanse the spaces we occupy of social change. The risk of turning to the messy politics of subaltern voice is embodied for a number of us then in our own negotiations of an academic home and finding a place that would sustain us in the academe, negotiating the question "What defines the health communication scholar?" Moreover, the slowness of embodied solidarities often calls for greater labor and attention that is placed on the everyday organizing and the politics of interrogating structures in an increasingly neoliberal university, driven by neocolonial rankings system originating from/in the West/North.

From our positions outside of the circuits of the global North then, the praxis of critical health communication is the everyday resistance work necessary to transform the neoliberal university (Heath and Burdon, 2013; Chatterjee and Maira, 2014). Embodied resistance teaches us to interrogate the politics of the very spaces we inhabit, and the ways in which subalternity is created everyday in these spaces. Our practices of solidarity with subaltern struggles for voice has taught us the vitality of solidarity when scholars are targeted and disciplined by the structures of the neoliberal university. Embodied criticality therefore for us is participation in dissent and lending solidarity to dissent that challenges the consolidation of power through authoritarian, state-managed, and corporate techniques. Embodied criticality is the re-organizing of universities as institutional structures. Through the creation of spaces and economic structures for community researchers, community organizers, activists in the university, the method of cultural centering performs embodied criticality, thus often inviting techniques of disciplining under the logics of accounting and management. When our TSW partners or our foreign domestic worker partners occupy places in the university with us, working together as researchers, the norms of institutions are disrupted, leading to various forms of abuse. Culture-centered work sensitizes us to the significance of transforming these spaces that we inhabit every day. We recognize the struggles of janitorial staff, cleaners, and maintenance workers as sites of critical health communication praxis. Ultimately, the embodied turn to culture-centered method suggests the recognition of the urgency of change in universities as the very spaces we inhabit through dissent, agitation, and the placing of the body in the frontlines of struggle.

Transforming Structures

Their universal appeal as the basis of knowledge claims forms the basis of culturally situated articulations that seek structural transformation (see Dutta, 2008). The recognition of the cultural nature of science and health knowledge, universalized in colonial interactions with the margins, forms the basis of recognizing the universalizing bases of culturally situated knowledge claims. The move-ment from the local to the universal mirrors the embodied movement of the critical health scholar from the margins to the center and back to the margins, through contingent and dynamic relationships with communities at the margins. This movement however is constituted in an active politics of transforming structures, challenging the very impediments established by the structures that actively erase subaltern voices.

The challenges of communication and health therefore lie in fundamentally transforming the structures that constitute the inequalities and ecological risks to health. That these structures can't be changed through incremental knowledge-based health communication solutions or simplistic behavior change solutions is itself a site of structural transformation. The hegemonic health organizations from the World Health Organization to the Centers for Disease Control and Prevention to UNICEF to USAID shape the health agenda through the interventions and communication solutions they sponsor. Based on the CCA for instance, the ongoing collaborations with women farmers in India identify the pressing public health concerns among farming communities in India besides the predominantly discussed suicides of the agriculturalists. Foregrounding the meanings of the public health concerns among the farming community puts forth an embodied politics of change that is fundamentally tied to reworking the politics of food, agriculture, and the ecosystem.

How critical health communication researchers collaborate with subaltern communities is also tied to actively imagining movements, collective bargaining, and political possibilities that transform structures. That the incremental addition to structures very much keeps structures intact re-focuses the work of the CCA on communication activism for changing structures. Structures therefore are contested, confronted by the participation of communities, with social change processes offering formations that anchor socialist health structures committed to equality.

Building Voice Democracies

By listening to the voices of the subaltern communities, the CCA seeks to construct knowledge from within, interrogating the hegemonic approach to health communication that enables dissemination of development interventions for modernization. Subaltern voices depict the possibilities of democracy that are worked out through everyday forms of participation that challenge the hegemonic constructions of health (Rall, 2018). The recognition that voice forms the heart of structural transformation also means that the work of cultural centering commits to building infrastructures for subaltern voices. The dominant structure reproduces itself by erasing subaltern voices; therefore, when the subaltern voices speak, the dominant structure works actively to erase it. Therefore, embodied health communication scholarship places the body of the academic as a method for critiquing the structure through the presence of subaltern voice. Here, solidarity and authenticity are integral to ensuring that the academic stays with the process of building infrastructures amid threats to the academic work, job security, and in other instances, health and life. Commitment sustains the ongoing work of building voice democracies so subaltern communities can participate in decision-making processes. Loyalty is not a theoretical construct in abstraction, but an embodied act that anchors our belongings in the project of dismantling neoliberal neocolonialism that fundamentally threatens the health and wellbeing of our species, ecosystems, and earth.

In conceptualizing critical health communication as embodied practice of resistance, we worked through ethnographic accounts of case studies that adopted the framework of the culture-centered approach to seek structural transformations. The body of the academic, crystallized through the concepts of commitment, solidarity, and authenticity is salient to the process of changing structures. We note that while often in critical scholarship, there are calls to changing structures at the end of pieces, the actual work of changing structures calls for an embodied practice that works through the academic body in imagining the possibilities of transformation. We also urge that the conversation on the CCA turn to the question of the commitments of our academic bodies to creating communicative equality within a larger project of building socialist infrastructures for health and well-being. In sum, we offer this account as an invitation to engage critically with our bodily formations as critical health communication scholars, asking: what does it mean to be doing critical health communication work?

DATA AVAILABILITY STATEMENT

The datasets generated for this study are available on request to the corresponding author.

ETHICS STATEMENT

This study was carried out in accordance with the recommendations of the National University of Singapore Institutional Review Board with informed consent from all subjects. The protocol was approved by the National University of Singapore's Institutional Review Board.

AUTHOR CONTRIBUTIONS

Each author contributed to various aspects of the paper. Specifically, authors that lead the campaigns highlighted in various sections of the paper wrote about the campaigns in the paper. The first author directed the center, conceptualized, designed, and guided the implementation of the interventions reported in the manuscript.

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Embodied Methods in Critical Health Communication

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At the center of critical questions posed about power and health communication are issues of embodiment—whose bodies are judged to be healthy and whose are not, which identities are affirmed and privileged and which are stigmatized and marginalized, which material practices are pathologized and which are lauded. Critical health communication (CHC) research may be enacted by critical-interpretive researchers who employ critical embodiment theorizing frameworks that guide their questions posed, co-construction of data, and forms of analysis and representation. CHC researchers are uniquely poised to attend to the embodied aspects of health, illness, health care delivery, and public health in order to improve the health of local and global communities.

Keywords: embodiment, critical research, critical health communication, qualitative methods, critical theory

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METHODS IN CRITICAL HEALTH COMMUNICATION

Critical health communication (CHC) research troubles the taken-for-grantedness of heath, illness, and health care by asking questions about power, inequities, and whose perspectives are rendered natural or normative and which are silenced (Zoller and Kline, 2008). At the center of such questions are issues of embodiment—whose bodies are judged to be healthy and whose are not, which identities are affirmed and privileged and which are stigmatized and marginalized, which material practices are pathologized and which are lauded. Moreover, the question of how the knowledge about bodies is constructed is itself a critical question that insists that the mind and body are a single, entangled entity rather than a binary in which the mental self possesses and controls the body as property (Ellingson, 2006).

Traditionally, CHC often centered on analysis of media and promotional campaign texts (Zoller and Kline, 2008), such as analysis of popular discourse surrounding the HPV vaccine (Thompson, 2010) and body mass index initiatives and public school children's report cards (Gerbensky-Kerber, 2011). Yet critical theorizing increasingly serves as a framework for critical-interpretive (qualitative) health communication studies that involve "experience near" (Warren and Karner, 2014) or naturalistic methods, such as interviewing, ethnography, and participatory action research (Lynch and Zoller, 2015) that focus on intersections of health, illness, and culture (Dutta, 2008). Social science practices that reflect interpretive, social constructionist, or arts-based perspectives reject (post)positivist ideals of objectivity, detachment, and prediction in favor of intersubjectivity, rich description, and the integration of the discursive with the material. CHC research is enacted by critical-interpretive researchers who employ critical theorizing frameworks that guide their questions posed, co-construction of data, and forms of analysis and representation. What makes research recognizable as CHC is not only the use of critical theorizing as a framework for analysis and the development of conventional research reports (e.g., feminist, poststructuralist) but also the infusion of critical sensibilities into every messy (Law, 2007), iterative (Charmaz, 2006; Tracy, 2019), creative (Lowenstein, 2015; Vaart et al., 2018), complex Lindlof and Taylor (2017), and wonderful (Ellingson, 2009; MacLure, 2013) research practice. Embodied sensibilities can shape every researcher move when inscribing fieldnotes, conducting interviews, or collaborating to make participatory data by attending to splendidly sensuous intersubjectivity.

My own CHC work continues to be rooted deeply within interdisciplinary, critical theorizing of embodiment, especially feminist, poststructuralist, and materialist perspectives. I frame critical qualitative research as an always already embodied communicative process (Ellingson, 2017a; Ellingson and Borofka, 2018). In this article, I briefly overview generative ways in which critical embodiment theorizing can enrich every process of CHC research that combines such theorizing with interpretive methods (e.g., interviewing, ethnography, participatory action research). I sketch current embodiment theorizing of the embodied self. Then I offer insights on ways in which attending to embodiment enriches all aspects of critical-interpretive research processes. The essay concludes with further possibilities for embodied CHC research.

CRITICAL EMBODIMENT THEORIZING

Traditional research methods reinscribe a mind-body dichotomy based on Cartesian philosophy that renders the body the possession of the self, as equated with the mind. Poststructuralists and materialist theorists (e.g., Manning, 2013) reject the metaphor of the body as a container of the self and theorize the body "as a material and visceral set of biological components and functions" (Ash and Gallacher, 2015, p. 69). Embodiment positions people

> as whole experiential beings in motion, both inscribed and inscribing subjectivities. That is, the experiential body is both a representation of self (a "text") as well as a mode of creation in progress (a "tool")… Embodiment is a state that is contingent upon the environment and the context of the body (Perry and Medina, 2011, p. 63).

Cultural meanings vary widely and exert dramatic power over how we come to interpret bodies and their signifiers. CHC scholars attend to bodies in order "to find the particularities in how minded bodies and worlds fit together" as mutually constitutive (Pitts-Taylor, 2015, p. 23).

Embodied CHC research integrates body, mind, and spirit, resisting Cartesian dualism, and positing that "we do not *have* bodies, we *are* our bodies" (Trinh, 1999, p. 258, emphasis in original). As Butler (1997) suggests:

> The body is not merely matter but a continual and incessant *materializing* of possibilities. One is not simply a body, but, in some very key sense, one does one's body... [T]he body is always an embodying of possibilities both conditioned and circumscribed by historical convention (p. 404; emphasis in original).

CHC explores the doing and materializing of our body-selves in everyday life within cultural, discursive, and material contexts. Body-selves are constituted both through relationships with others—interpersonally, organizationally, in communities—and within larger social and political structures (Hudak et al., 2007). Moreover, body-selves not only are influenced by culture and interaction but "can also be seen to actively negotiate, adopt, or resist normalizing discourses. This is a process in flux... Lived bodies are... agential and productive, with a life of their own" (Harris, 2015, p. 9). Likewise, neuroscience confirms that brains are not fixed but exist in a continual state of flux known as *plasticity*; brains entangle with the surrounding world, adapting and changing through our embodied experiences (Schmitz and Höppner, 2014).

A notable component of such embodied entanglement is materiality. The body is central to our capacity to exercise agency in the world, and we often use tools or objects when we act, including when we conduct research (Shilling, 2012); the "materiality of the field includes such things as human bodies, buildings, desks, books, spaces, policies, theories, practices, and other animate and inanimate objects. These materials are granted agential nature and undeniable affectivity, or an undeniable force in shaping inquiry" (Childers, 2014, p. 602). Actor-Network Theory (ANT) focuses not just on human bodies interacting with other human bodies, but also mutually constitutive encounters with animals, natural and made objects, and discourses (Latour, 2005). CHC research attends therefore to how the "management and experience of the body is *assembled* through its position in a complex *network* of material, technical, natural and ideational phenomena" (Shilling, 2012, p. 76; emphasis in original). Embodied CHC research centers materiality within networks of biomedical technologies (e.g., surgical scalpels, dialysis machines), healthcare delivery practices, public health systems, and persistent and pervasive socioeconomic inequities.

EMBODIED PRACTICES IN CHC RESEARCH

In this section, I review embodiment theorizing as expressed in theoretical frameworks, data collection, analysis, and representation. The seemingly linear presentation of these phases of the research process belies the iterative, overlapping, and messy reality of most qualitative research.

Embodied Frameworks

Theory provides starting points for inquiry and grounds research questions in critical perspectives. Feminist, new materialist, posthumanist, poststructuralist, critical race, queer, and other forms of critical theorizing provide rich impetus for posing critical questions about health and illness (Charmaz, 2017). At the same time, critical theories are being developed within health communication that illuminate the deeply embodied experience of health and illness. For example, Managing Meanings of Embodied Experiences theory (MMEE) (Field-Springer and Striley, 2018) bridges phenomenological (Merleau-Ponty, 1962), pragmatic (Dewey, 1954), and feminist (Young, 2005) theorizing of embodiment with an embodied conceptualization of health communication (Zook, 1994) to produce an innovative framework for understanding communication about health as rooted in embodied experiences. The theory is structured as a three-layer model of being, doing, and directed becoming through embodied experiences. As such, MMEE theory formed a fitting framework for an analysis of long-term cancer survivors' (LTS) everyday embodiment as people who live in/as bodies that remain not merely *influenced by* but to a great degree *constituted through* cancer treatments and late effects of those treatments (Ellingson and Borofka, 2018). Field-Springer and Striley established the critical role of communicating with others as the primary mechanism for understanding our material realities and imagining alternative possibilities for embodied selves. My study illuminated LTS' embodied experiences and sense making post-cancer as they communicated with others about health, illness, coping, and particular embodied experiences. Russell (2018) explored the "unspoken qualities of embodied communication" while conducting fieldwork on addiction and recovery, which she connected to MMEE theory.

Other CHC scholarship uses narrative and performative frameworks to illuminate embodied power dynamics surrounding health and illness as they intersect with disability and ableism (Scott, 2012, 2015; Spencer, 2019) (in)fertility (Johnson and Quinlan, 2016); pregnancy (Peterson, 2016), heteronormativity (Arrington, 2012; Silverman et al., 2012; Hudak and Bates, 2018), aging (Roscoe, 2018); and dying (Tullis, 2013; Sharf, 2019). A particularly compelling autoethnographic CHC study explores a researcher's (lack of) credibility when she seeks treatment for chronic pain and encounters health care providers and community members who greet her pain-wracked body with doubt, skepticism, and even ridicule (Birk, 2013). Narrative and performative CHC explorations offer nuanced depictions of the radical specificity of lived experiences of health and illness, while casting a critical eye toward their cultural, organizational, and interpersonal contexts (Sotirin, 2010).

Embodied Data

Eschewing post-positivist legacies of data, CHC researchers can productively conceptualize data as we actively co-construct with participants through *data engagement*, a critical approach that embraces intersubjectivity, materiality, and embodiment (Ellingson and Sotirin, 2019a,b). Making embodied data requires being present in the (traditionally material and now also virtual) space(s) under study. Being "there" and writing about what researchers see, hear, feel, smell, taste, and otherwise sense provides researchers with the makings of embodied data. Rather than tidy data sets, embodied data comprise loose assemblages (Denshire and Lee, 2013) that are produced through the intra-action (mutual constitution) of the researcher, participants (and other people in the setting), actants (non-human, agential objects), and cultural discourses within particular places and times (Barad, 2007). Embodied data are textured, scented, visceral; embodied data are not merely collected but "wondered, eaten, walked, loved, listen to, written, enacted, versed, produced, pictured, charted, drawn, and lived" (Koro-Ljungberg and MacLure, 2013, p. 221). The constitutive processes through which embodied data come into being brings participants' and researchers' body-selves into focus to engage the reflexively with "the sensorimotor magnetism of the universe in question" (Wacquant, 2009, p. 123) and produce "stories in the flesh" (Warr, 2004, p. 586). From a CHC perspective, being there in the ethnographic field is a fuzzy process, fluid, with emphasis on process, participation, and ongoing "becomings" of embodied and emplaced body-selves, including that of the researcher (Ellingson, 2017a). Fieldnotes, interview transcripts, and other data should convey "thick description" of the people and culture studied, including sensuous details of embodied (verbal and non-verbal) communication (Geertz, 1973) and intra-actions (i.e., mutually constitutive influences) among people, objects, and discourses (Barad, 2007) in an ongoing "bodily and material 'conversation' with the field [setting]" (Hopwood, 2013, pp. 228–229; see also Pink, 2009).

CHC explores the sensorium, or participants' intersecting/overlapping sensory capacities that focus not only on what participants see and hear but also on touch, taste, smell, texture, temperature, and movement (Paterson, 2009). In both formal and informal (ethnographic or spontaneous) interviews, participants' stories illuminate memories of how their bodies felt in particular moments and where in their bodies they experienced emotion. For example, one ethnographer of an in-patient hospice noticed from a hallway sounds and smells "such as beeping machines, patients sobbing, and meals being wheeled into patients' rooms, and the smells of antiseptic, drugs, and food, which permeated the ward" that gave her sensory clues as to what patients experienced inside their rooms (Wray et al., 2007, p. 1396). Another CHC ethnographer participated in "fun runs" (recreational, community races) and richly described embodied performances of thin/fit privilege, of breathing hard and having a reddened face when struggling to keep pace with other runners, of the pleasure of eating "bad" food that they had "earned" with their run (e.g., pizza and beer), and performances in which runners "embody ease by displaying a lack of concern" (through both speech and non-verbal communication such as facial expressions and gestures) about maintaining their ability to run fast and remain thin naturally (Luna, 2019, p. 261).

Embodied Data Analysis

Researchers' whole bodies process data, not just our brains. Yet we may forget that data analysis is physical as well as mental: "analytical work is in an important sense a material praxis" (Konopásek, 2008, n.p.). Qualitative researchers in the early stages of data analysis achieve "intimate familiarity" with their textual materials by rereading and reflecting (Warren and Karner, 2014). CHC researchers engage in embodied processes of intimate familiarity through our bodies—we read data, listen to recordings, view photographs, maps, or other images, make notes with our hands, and so on. MacLure (2013) suggested that scribbling and underlining on printed data constitutes an embodied process, a connection to the materiality of data and of the entire analysis process which is accomplished with hands, eyes, ears, shoulders, and back, the lap that holds the laptop computer, and so on. Those who have used or continue to use printed paper copies, colored pens and pencils, scissors, paper clips, and so on for data coding and manipulation, create new objects (i.e., groupings of quotes and notes) within a "textual laboratory—which has the power to shrink time and space distances between observable phenomena so that everything important is present and under control" (Konopásek, 2008, p. 22). The physical rearrangement of documents used in analysis—different types of data, analytic memos, and reflections, notes on research processes, even to-do lists, help researchers think through their analyses. Explained one researcher:

> I moved data around, generated queries around "codes," and re-arranged the piles to re-engage my memories of my field experiences. These material practices, pen to paper, hand moving to underline and write, "doing," were a necessary part of my analytic practice.... The promiscuous materiality of analysis… provided a way to (re)engage the bodily and affective conditions of research (Childers, 2014, p. 821).

Rather than merely housekeeping chores or computer clicks, data analysis is grounded deeply in the material world. Researchers' choices make about organizing and handling our data materials *matter*, and they should be carefully considered in terms of fit with researchers' personality and preferences, their participants' capacities and needs, and the types of data with which researchers are engaged. Even those CHC researchers who use entirely digital means for analyzing data engage in material manipulation of excerpts of data. Using screens, track pads, and an electronic "mouse," "we can *create, see,* and *manipulate* various [data] objects. These objects can be of different sizes and shapes; they can be hidden, moved, split, colorized, grouped and regrouped, forgotten and rediscovered on unexpected occasions" (Konopásek, 2008, n.p.; emphasis in original). The grouping, networking, coding, and commenting on quotes enables researchers to sense and construct embodied connections among ideas, deeply impacting our ongoing (re)construction of meaning(s).

Attention to embodiment may be facilitated further by practicing methodological playfulness and unruliness, drawing from a multitude of approaches and transgressing the strict parameters of methods. Of course, such transgression must be carefully considered, but embodied possibilities abound when CHC researchers think outside the box. Indeed, the common analytical practice of coding, "when practiced unfaithfully, without rigid purpose or fixed terminus… allows something other, singular, quick and effable to irrupt into the space of analysis. Call it wonder" (MacLure, 2013, p. 164). Wonder is embodied, "simultaneously Out There in the world and inside the body... distributed across the boundary between person and world" (MacLure, 2013, p. 181). Likewise, Childers (2014) embraced the sexualized term *promiscuity* to infuse analysis with pleasure, eroticism, and edginess. Her analytic practices

> became promiscuous. Grounded theory, situational analysis, pleated texts, rhizomatics, policy analysis, and discourse analysis were suggestions and flexible tools rather than recipes. I was doubly promiscuous, engaging in conventions that might be the very source of analytic containment, yet breaking that containment by (mis)appropriating them. The promiscuous materiality of analysis came alive through this affective engagement that provided a way to (re)engage the bodily and affective conditions of research (Childers, 2014, p. 821).

Like Childers and MacLure, CHC researchers can embrace embodied play as integral with analysis. Crystallization provides one model of how disparate modes of sense making and varying genres or mediums of analysis can co-exist in playful, generative tension within a research project to complexify results (Ellingson, 2009).

Moreover, CHC researchers' knowledge is interwoven throughout our bodies with gut feelings, emotions, and other bodily sensations that arise as we engage in serious play with data—tears, muscle tension, headaches, smiling, trembling—and offer clues to embodied meanings embedded in our own and our participants' bodies. During data analysis, researchers' bodies become immersed in textual data and make connections, which "involv[es] the goal of pulling together the strands of its meaning... A felt sense of the strands is present in our bodies. When we direct our attention to the felt sense, it gives rise to memories, associations and images" (Rennie and Fergus, 2006, p. 494). Bodén (2015) described the visceral sensation of inevitable connection with particular bits of data: "Something dragged me back to the situation, it sparkled and glowed... charmed me, and discomforted me" (p. 193). Other data integrate with researchers' bodies, as though data were

> ingested into my blood stream and body's fibers.... Some curious fragments seep through my pores, in molecular ways becoming part of my flesh, (de)composing with my body, necessarily living with and in me, entering a new kind of fleshly decay and analysis that goes beyond coding (Holmes, 2014, p. 783).

CHC researchers can employ our guts consciously (and seek our participants' gut reactions), as we sort through data, discern patterns, construct coherent categories, develop theoretical perspectives on data "hot spots" (MacLure, 2013, p. 172) and otherwise (re)assemble data into new forms. We can draw on gut and intuitive senses of what fits our data and emerging understandings.

CHC researchers are increasingly owning their embodied analysis practices and their implications. For example, Warin and Gunson (2013) explore the complexities of data collection and analysis in obesity research, employing a poststructuralist framework to explore their use of language and their own embodiment as its relates to their reflexivity and interpretation of data. Likewise, Lupton (2019) provides a compelling overview of how feminist new materialism forms a generative framework for creating and analyzing qualitative data on experiences of embodiment and digital health. Lupton reflects on her education, past research experiences, embodied identities such as female, "Anglo-Celtic," able-bodied, and economically privileged as she makes sense of others' experiences of digitized and corporeal health (and illness).

Embodied Representation

CHC research typically reflects normative research report writing conventions, emulating traditional deductive logics even when making critical claims about power, health, and illness. I offer two modes of embodiment for CHC; first, conventional reports can be enhanced through embodied representation; second, CHC scholars can harness the power of multiple genres to illuminate embodiment.

CHC research reports may engage with the radical specificity of participants' lives (Sotirin, 2010). While Sotirin's focus is on autoethnography, I articulate radical specificity and embodiment as integral to representation in any genre of CHC research. Resisting the framing of difference as variations of a single monolithic phenomenon, difference can be honored through an articulation of the "*radical specificity* of living a life, not in the sense that we all live our own lives but in the sense that life is lived in the flows, multiplicities, and provisionality of each moment, event, emotion" (Sotirin, 2010, n.p.). In this way, the goal of scholarship shifts from evoking recognition, empathy, and commonality of experience to embracing "the opportunity to think beyond the dominant, the familiar, and the common" (n.p.) to look at moments of a lived life. Sotirin urges readers to accept that there is no essential core experience which researchers and participants all express in somewhat differently embodied ways. Instead, "radical specificity opens unfamiliar connections and relations that move both beyond and against the familiar storylines, emotional verities, and the all-too-recognizable critiques of cultural-political constraints" (n.p.). In other words, radical specificity is reflected in stories that do not conform to cultural clichés—e.g., the harried working mother or the tireless warrior mother advocating for resources for her child with learning disabilities. In this way, radical specificity as a practice "creatively dismantl[es] the affective relations defining the institution and experience of motherhood [for example] and allow[s] the singularity of those relations to show us something different" (n.p.). That "something different" can be radically specific ways of living bodies in moments, rather than generalizable truths or commonalties. For example, Lord (2004), a white lesbian in her 50s, created an assemblage of her experience with breast cancer. The messy text consisted of emails, rants, lists of biomedical facts, and photographs—none of which fit neatly together—forming an example of queering cancer (Bryson and Stacey, 2013) through "an autobiographical account of life with cancer that explicitly and elegantly refuses the canonical requirements of biography" (Bryson and Stacey, 2013, p. 204). In this way, Lord does not provide readers ready access to empathy on the basis of their commonality of experience; rather she offers snarky comments, refers to herself in the third person as "Her Baldness," and otherwise remains irreverent.

Radical specificity applies to narratives and the opportunity to reach not for the canonical moment of commonality but for the odd, irreverent, embarrassing, or confusing moment instead. Yet radical specificity also may help to enrich the construction of themes or categories across a data set. That is, instead of gathering interview quotes and fieldwork excerpts that form variations within a coherent theme, researchers could instead (or also) think of the ways in which the radical specificity of lived moments manifest not a singular experience or identity but together illuminate the intersectional complexity of lived experiences of body-selves. As an example, I want to revisit a study my collaborator and I conducted that addressed women with breast cancer's satisfaction with their physicians' ways of communicating (Ellingson and Buzzanell, 1999). In retrospect, we missed the opportunity to highlight the radical specificity of some moments in our data, such as the embodied experience of surgery for one participant who was pregnant when diagnosed with breast cancer. We acknowledged the particularity of participants' lives through a table in the methods section that provided bits of information about each participant's age, diagnosis, and circumstances, yet we still positioned concepts such as respect or caring as common experiences of a singular phenomenon for which we provided illustrative examples. Radical specificity reminds researchers that life is lived at the intersection of common stories with the specific moments in the ebbs and flows of a particular life.

Another meaningful way to engage with embodiment theorizing in CHC research representations is to use a crystallization framework to frame multiple forms of analysis and multiple genres/media of representation within a research project (Richardson, 2000; Ellingson, 2009). For example, one project explored the everyday embodiment of health and illness of long-term cancer survivors (LTS) whose initial cancer treatments cured their disease yet resulted in "late effects," or chronic illnesses and conditions caused by chemotherapy, radiation, surgery, medications, and other biomedical treatments. This CHC project crystallized through systematic qualitative analysis informed by feminist theory (critical-interpretive research report); a mixed methods survey (brief, post-positivist report); a critical essay about cancer survivorship advocacy; an art installation; a website that provided photos and quotes from participants, information on late effects, and links to online resources for long-term survivorship; and a reflection on photovoice methods as a mode of sense making with LTS. Together, these representations illuminate, obscure, and complexify researcher and participant bodies in a variety of genres (Billingslea and Ellingson, 2015; Borofka et al., 2015; Wagner et al., 2016; Ellingson, 2017b; Ellingson and Borofka, 2018). Another great example of crystallization in CHC is the work of Harris (2009, 2012, 2015) who investigated drug use and living with Hepatitis C. She created a video that complemented scholarly articles, shared her personal history of drug abuse and recovery, and engaged in praxis with strategies for harm reduction in communities of (recovering) addicts. Crystallization offers one path to representing bodies as refracted through a prism of multimethod/multigenre analysis and representation, illuminating both material and symbolic needs of a variety of stakeholders implicated in CHC research projects.

CONCLUSION

Over a decade ago, I was among the scholars who decried the lack of embodiment (particularly of researchers) in health communication research (Ellingson, 2006). This essay documents meaningful progress in incorporating critical embodiment theorizing as part of the larger rise to prominence of CHC research. Embodied CHC illuminates knowledge production processes, complexifies analyses, and enriches both conventional and narrative/artistic representations of research. Going forward, CHC scholars can mobilize embodiment theorizing in new and creative directions. Critical embodiment sensibilities complement participatory action research, community based participatory research, and arts-based research methods particularly well because of their emphasis on material conditions and health disparities (e.g., Greiner, 2012; Marsh et al., 2017; Kennelly, 2018). Another generative site for embodiment theorizing in CHC is the digital domain, including studies of health information on the internet, online social support groups, telemedicine, and big data analyses of how consumer bodies are commodified and marketed to pharmaceutical companies (e.g., Selke, 2016; Gregory, 2018; Robitaille, 2018). Each of these topics would benefit from attention to the ways in which particular bodies are highlighted or obscured; gender, race, age, sexuality, and other key identities are constructed in relation to health; and the interfacing of bodies with the computers, smartphones, or other technologies that enable digital access. CHC scholars are uniquely poised to attend to the embodied aspects of health, illness, health care delivery, and public health programs in order to improve access, education, and health for local and global communities.

AUTHOR CONTRIBUTIONS

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

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Soul Food: [Re]framing the African-American Farming Crisis Using the Culture-Centered Approach

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Historically, African-American farmers faced a long and challenging struggle to own land and operate independently. In recent years, several factors, including unfair policy legislation, institutionalized racism, the mechanization of agriculture, and increases in agricultural technology have exacerbated land loss and decreases in farm ownership. Currently, African-American farmers are vastly underrepresented, comprising just 2% of the nation's farmers, 0.5% of farmland and 0.2% of total agricultural sales. As a site for inquiry, this topic has been examined across many academic sub-disciplines, however, the literature has not yet explored how the erasure of the African-American farmer influences the conversation about broader diet-related health disparities in the U.S. This overlooked perspective represents a novel approach to rethinking public health interventions and may improve methods for communicating messages about healthy eating to the African American community. In this essay, we extend (Dutta, 2008) the Culture-Centered Approach (CCA) to foreground the lived experiences and perspectives of a small cohort of African-American farmers ($n = 12$) living in the U.S. Mid-South as an entry point to address this underexamined area of research and inform future methodological directions of study. Two key themes emerged from the thematic analysis: (1) erasure of the African-American farming tradition and land loss; and (2) solutions to change. Drawing on the understanding that systematic land loss in the African-American community has contributed to wealth disparities between African-Americans and Whites, we argue that the erasure of the African-American farming tradition within mainstream discourses has created communication inequities that disenfranchise the African-American community and may contribute to broader health inequities in food system. Our findings may offer important insights into the methodological development of more effective health campaigns within these communities.

Keywords: African-American farming, usda, culture-centered approach, agriculture, thematic analysis

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INTRODUCTION

Historically, African-American farmers faced a long and challenging struggle to own land and operate independently. Since the beginning of the twenty century, land ownership by African-American farmers declined nearly 50% every 10 years (USDA NASS., 2014), which nearly tripled the loss of land of White farmers during the same period (Wood and Gilbert, 2000; Grant et al., 2012). Several factors contributed to this decline, including unfair policy legislation, institutionalized racism, the mechanization of agriculture and increases in agricultural technology (Reynolds, 2002; Hinson and Robinson, 2008; Wood and Ragar, 2012). These factors changed the landscape of contemporary agriculture and erased the narratives of structural discrimination and material inequities that historically burdened the African-American farming community.

Currently, African-American farmers are vastly underrepresented concerning both individual laborers and land ownership. According to a report from the United States Department of Agriculture (USDA), African-American farmers represent <2% of the nation's farmers, operate <0.5% of the country's farms and account for 0.2% of total agricultural sales (USDA NASS., 2014). Regarding land ownership, African-American farmers represent just 2% (68,056) of landowners (in comparison to 96.2% of Whites, or 3,412,080) and 0.9% (7,754) of total acreage owned (in comparison to 98.1% of Whites, or 856,051; USDA NASS., 2014). Overall, African-American farmers have been devastated economically, politically, and socially, and as such, are more likely to commit suicide, become depressed, and live in poverty compared to White farmers (Horst and Marion, 2019) these dire circumstances have all but eliminated African-Americans from the contemporary agricultural landscape.

Coinciding with this exigency, disparities in health and disease between various segments of the population (e.g., race, ethnicity, gender, sexual orientation) have emerged as a pressing public health concern in the United States and become a major focus of public health research in recent decades (Centers for Disease Control Prevention., 2008). Studies have shown that diet is a primary contributor to disparities in many chronic conditions and diseases and represents an important area for examination (Satia, 2009). Yet, many dominant approaches that address diet-related health disparities employ top-down programs that locate meaning in dominant articulations of health communication (e.g., expert-driven policies and measurement criteria)–often assuming universality (e.g., Western-centric theoretical models), effectiveness (e.g., cause-effect rationales) and innovation (e.g., taken-for-granted need for intervention) in their methodology (Dutta, 2010). Often missing from these efforts is a focus on cultural communicative barriers which may limit or reinforce such disparities (e.g., lack of representation, cultural norms). Recent health communication scholarship has called for the restructuring of health agendas from traditional top-down approaches to more emancipatory models that incorporate nuanced cultural, structural and other barriers to commitment often obscured or overlooked in dominant paradigms.

One emerging model is the Culture-Centered Approach (CCA). This framework suggests that the exclusion of marginalized communities from dominant communication platforms is connected to their disenfranchisement and lack of access to vital resources (e.g., healthy food) and aims to address health disparities by opening spaces for dialogue to generate locally-driven agendas and policies. In this essay, we employ the methodological underpinnings of CCA to foreground the lived experiences and perspectives of a small cohort of African-American farmers living in the U.S. Mid-South using thematic analysis (Braun and Clarke, 2006; Silverman, 2006). Similar qualitative studies have used the CCA to examine diet-related health disparities among marginalized populations (Koenig et al., 2012; Dutta and Jamil, 2013; Dutta et al., 2016), however this is the first to take an inductive approach to map emergent themes onto the core constructs of CCA (culture, structure, agency).

Drawing on the understanding that systematic land loss in the African-American community has contributed to wealth disparities between African-Americans and Whites (Doron and Fisher, 2002; Gilbert et al., 2002), we argue that the erasure of the African-American farming tradition within mainstream discourses has created communication inequities that disenfranchise the African-American community and may contribute to broader health inequities in food system. This paper contributes new knowledge to scholarship on the African-American farming crisis and informs future methodological directions of study. The following research questions guided our analysis: (1) How do African-American farmers in the Mid-South describe cultural and structural barriers and opportunities for African-Americans in the U.S. agricultural industry? (2) How do African-American farmers in the Mid-South describe legacies of racism, discrimination and other forms of inequities? The paper will unfold as follows: first, a review of literature examining contributions to the decline of the African-American farmer, health disparities and the modern food landscape. Then, we discuss our theoretical framework and method, and next, provide the results from the thematic analysis. The paper concludes with a discussion section at the end.

CONTRIBUTIONS TO THE DECLINE OF THE AFRICAN-AMERICAN FARMER

Since the end of slavery, African-American farmers have struggled to gain economic capital and self-sustainability (Smith, 2004). The rapid and continual decline of African-American farmland can be somewhat attributed to advancements in agricultural technology and the mechanization of equipment, which increased the productive capacity of farms exponentially (Brown and Larson, 1979; Brown et al., 1994). Compared to White farmers, African-American farmers had far more difficulty accessing these transformative technologies (Wood and Gilbert, 2000; Green et al., 2011). Further, during this period of rapid innovation, structural changes in agricultural policy, such as "New Deal" era farm subsidy programs, favored large-scale farms, which were mostly owned by Whites, and African-American farmers were systematically targeted by discriminatory banking policies (e.g., mortgage foreclosures) and forced acquisition of their farmland through "heir property" (Reynolds, 2002; Hinson and Robinson, 2008; Schell, 2015; i.e., fractioned land ownership and partition sales). Together, these events marginalized the African-American farming population and erased much of their contributions from the modern agricultural landscape. Scholars have not yet considered how the erasure of African-American farming in the modern food landscape contributes to significant health inequities in the food system.

HEALTH DISPARITIES, ERASURE OF AFRICAN-AMERICAN FARMING, AND THE MODERN FOOD LANDSCAPE

Research indicates that African-Americans suffer disproportionately in comparison to Whites in terms of disease incidence and mineral deficiencies related to nutrition (Wang and Chen, 2011; Kirkpatrick et al., 2012). For example, data from the National Health and Nutrition Examination Survey (NHANES) III (1999–2002) found that African Americans were 43% less likely than Whites to meet USDA fruit and vegetable guidelines (Casagrande et al., 2007). According to the Centers for Disease Control and Centers for Disease Control Prevention. (2017), African-Americans are nearly twice as likely to be diagnosed with diabetes than their White counterparts, with prevalence rates of 13.4 and 7.3%, respectively. Although several factors have been identified as possible culprits, such as socioeconomic status (Eyler et al., 2004; Bahr, 2007), psychosocial factors (Watters et al., 2007, 2008) and cultural factors (Kumanyika et al., 2005; Boyington et al., 2008), one potentially overlooked contributor is the erasure of the African-American farming tradition within mainstream discourses and subsequent communication inequities that emerge as a result.

The erasure of the African-American farming tradition detached much of the African-American community from their connection to the land and prevented African-American farmers from competing in the modern agricultural landscape (Balvanz et al., 2011; Daniel, 2013). Moreover, dominant tropes of health and healthy eating practices universalized values specific to Whites and White culture (e.g., eating organic food, tropes of "getting back to the land" and "putting your hands in the soil") and largely ignored contributions and cultural histories from other groups. For instance, the Alternative Food Movement (AFM), which is a social movement based on developing alternatives to the corporate agribusiness domination of the global food system, emerged as a potential model to improve food access and alleviate food system-generated issues, such as food insecurity (Burdick, 2014; Grauerholz and Owens, 2015), but there have been no significant initiatives by leaders of the AFM to involve African-American farmers or an acknowledgment of their farming tradition in health-promoting initiatives.

Further, AFMs seek to build community and promote inclusivity, participatory democracy, and serve as spaces of contestation against the globalized food system (Kloppenburg et al., 1996; Goodman et al., 2012), but despite these purported benefits, most AFMs see people of color as marginalized and disenfranchised populations, and these narratives have profound influences on who participates and leads the movement, what is considered "healthy" food, and how resources are allocated (Myers and Sbicca, 2015; Broad, 2016).

Scholars such as Guthman (2003, 2008) and Alkon (2012) argued that the valorization of dominant tropes in alternative agriculture such as "community" and "democratic values" embodied Whiteness and reproduced privilege by emphasizing rhetorics of individual-level accountability and personal responsibility, and obscured or ignored altogether many of the structural constraints which contributed to the creation of such realities. Similarly, Slocum (2006, 2007) characterized AFM institutions as "White spaces" with regards to market vendors, patrons, and management. The spatial coding of AFM institutions as "White spaces," along with rhetorics of individual-level accountability and personal responsibility, may function as a barrier toward the participation of African-American farmers because it perpetuates the same system that historically disenfranchised their land rights and displaced them economically (Allen and Guthman, 2006; Holt-Giménez et al., 2011; Alkon and Mares, 2012; McClintock, 2014).

Another way that the African-American farming tradition gets marginalized within contemporary discourses is through the appropriation of indigenous African farming techniques, particularly in the organic farming sector. Racism is embedded within the roots of the organic farming sector and can be traced back to Nazi Germany and the nationalistic British Soil Association, whose teachings were adopted by organic farmers in the 1970s by the political leanings of the New Left with the rise in back-to-the-land and counter-culture social activism as a way to promote social equality (Guthman, 2008; Alkon, 2012). Several scholars have drawn attention to how revisionist interpretations of organic agriculture in mainstream U.S. culture worked not only to mask the historical contributions and challenges of people of color in food production but also re-centered the small-scale White farmer as the American agricultural icon and face of organic farming (Allen, 2004; Alkon and McCullen, 2010). In *Farming While Black: Soul Fire Farm's Practical Guide to Liberation on the Land*, Penniman (2018) described how modern forms of polyculture (i.e., the process of growing plants of different species as a way to increase plant biodiversity and make crops more resilient to climate variability and extreme weather conditions—a staple in modern organic farming) can be traced back several 100 years to indigenous farmers from countries in the West African region such as Ghana and Nigeria, yet often West Africans were not acknowledged for their historical contributions to the movement. Similarly, Guthman (2011) highlighted that many contemporary organic agriculture spaces were often burdened by their implicit attachment to Whiteness, which prevented such arenas from adequately engaging with concerns of attribution and ownership.

A combination of the legacies of sharecropping and tenant farming, issues of "heir property" and the discriminatory federal policies has severely impacted the ability of African-Americans to own and operate land. In the context of health disparities, public health scholarship has identified both land ownership and maintaining a cultural connection to the land as important social determinants of health (Olson and Anderson, 2013; Breitkreuz et al., 2014). However, to date, studies have not explored how the erasure of the African-American farmer influences the conversation about broader health disparities in the U.S. In this article, we draw on the CCA to foreground the lived experiences and perspectives of a small cohort of African-American farmers living in the U.S. Mid-South as an entry point to address this underexamined area of research. Below is a description of the central tenets of the CCA.

THE CULTURE-CENTERED APPROACH TO COMMUNICATION

The CCA is a methodological and theoretical framework for examining and interpreting the lived experiences of marginalized communities (Airhihenbuwa, 1995; Dutta, 2008). Drawing from subaltern and postcolonial studies theory (Fanon, 1963; Freire, 1972; Spivak, 1988), the CCA suggests that understandings for interpreting health are generated through mutual dialogue between community members and interventionist. Opposite of dominant approaches of health communication, whose agendas are controlled by outside experts, the CCA foregrounds the importance of listening to local communities to better understand how health issues become interpreted and communicated. For researchers, the CCA marks a shift from their traditional role as an interventionist, who directs and implements campaigns, to that of a listener who participates in dialogue with community members (Dillon and Basu, 2013).

Fundamentally, the CCA links listening with social change, in that it centers on engaging with the broader structures of erasure and domination, with the ultimate purpose of disrupting oppressive methods of organizing through grassroots efforts (Desmarais, 2007). Through this process, the emphasis on listening in the CCA becomes grounded within a transformative agenda of social change and justice (Dutta, 2014). The CCA is situated at the intersection of culture, structure, and agency.

Culture refers to the localized values, beliefs, and philosophies of a group or community. Structures refer to how resources are organized in society (Airhihenbuwa, 1995). In the context of health, structures exist at the micro-level (e.g., community-level medical services, means of transportation, channels of communication and health-promoting resources such as food access), meso level (e.g., media platforms) and macro-level (e.g., national and international political coalitions and health organizations; Basu and Dutta, 2008). Structures across these different levels work symbiotically and can either hinder or improve an individual's ability to engage in health-promoting behaviors. Agency refers to the ability of individuals to enact choices and negotiate structures that incorporate their lives.

As a guiding framework, the CCA is well-aligned to critically examine dominant discourses of African-American farming. It adds to the understandings of how African-American farmers describe barriers and opportunities for farming in the agricultural industry in three primary ways: (1) it de-normalizes dominant narratives (e.g, economic and sociological/demographical data) of African-American farming in the U.S. by highlighting alternative paradigms; (2) it privileges non-traditional forms of resistance as an entry point for upsetting the status quo, by challenging hegemonic norms and taken-for-granted assumptions; and (3) it centers on engaging with the broader structures of erasure and oppression, with the ultimate goal of disrupting dominant modes of organizing through grassroots activism.

METHODS

Overview

The research sites for this study were the Black Farmers Agriculturalists Association (BFAA) and the Mississippi Minority Farmers Alliance (MMFA) located in Memphis, TN and Okolona, MS, respectively. Access to the study population was gained using snowball sampling. The primary method of data collection was in-depth, semi-structured interviews. A total of 12 individuals participated in the study. Data analysis incorporated two primary steps: (1) an inductive thematic analysis using the constant comparison method (Braun and Clarke, 2006; Silverman, 2006); and (2) mapping the emergent themes onto the core constructs of the CCA.

Context: U.S. Mid-South

The Mid-South is a region in the U.S. consisting of states North Mississippi, Southern Missouri, Western Kentucky, Central, Northeast and Northwest Arkansas, and West Tennessee—anchored by the Memphis metropolitan area. As a site for inquiry, the region presented a rich area for insights into understanding the perspectives of African-American farmers. Historically, land ownership has been a key cultural and political asset in the region for African-Americans. Despite the national statistics regarding land loss among African-American farmers, there remain a concentration of African-American farm owners who are supported by a network of regional institutions which aim to advance the "local food and culture economy" (Beaulieu and Littles, 2008, p. 2). This context offered a unique entry point for uncovering the locally constituted meanings and lived realities of the African-American farmer today.

Research Site

Black Farmers and Agriculturalists Association

The Black Farmers and Agriculturalists Association (BFAA) is a national, non-profit member-based organization that provides guidance and support to African-American farmers in the U.S. and abroad. Formed in 1997, the organization has a membership of over 1,500 farmers nationwide and 21 state chapters. In addition to providing support for African-American farmers, BFAA was one of the lead organizers of the 1999 USDA Class Action Lawsuit Settlement *Pigford v. Glickman*–a civil action which claimed that the USDA had discriminated against African-American farmers on the basis of race and did not properly investigate grievances from 1983 to 1997, resulting in the USDA forced to pay approximately $1.06 billion in cash, tax and debt relief (Cowan and Feder, 2013)– providing resources and educational materials to affected farmers. The organization is headquartered in Tillery, North Carolina.

Mississippi Minority Farmers Alliance

The Mississippi Minority Farmers Alliance (MMFA) is a community-based agency that provides outreach assistance to socially disadvantaged, limited resource, and veteran farmers and ranchers in Northeast Mississippi. As a non-profit entity, some of their services include conducting on-farm assessments, sponsoring on-site farm training and youth workshops as well as promoting sustainability. Additionally, the MMFA maintains partnerships with various corporate entities, including the USDA, Alcorn State University Small Farm Development Corporation, and the American Red Cross.

Recruitment

Access to the participant population was gained using snowball sampling. Recruitment outreach efforts were facilitated by the executive director at each research site in addition to email and phone calls. A total of 12 participants took part in the study (11 males and 1 female; also see **Table 1**). Pseudonyms were used throughout the document to protect the privacy of participants. Individuals were considered eligible to take part in the study if they self-reported as Black or African-American, owned or worked on a farm for over 1 year in the Mid-South (e.g., Arkansas, Mississippi, or Tennessee area), and were over 18 years of age. Before participating in the study, a short demographic pre-survey screener was administered to determine eligibility. During recruitment, participants first signed up with the lead author (AC) during his on-site visits at both locations, where he contacted them later to establish a time and location that worked best for them to meet. Once a time and location were established, he met with participants to conduct the interviews. Before each interview, he explained all the procedures and let each participant know that their participation was voluntary and that they could choose to opt-out at any point during our conversation.

TABLE 1 | Participant Characteristics ($N = 11$).

	Age	Sex	Production	Education
Gregory	56	Male	soybean/ corn/ produce	BS
Delvin	62	Male	soybean/ corn/cotton	HS
Lawrence	70	Male	produce	BS
Keith	60	Male	soybean	PhD
Jesse	52	Male	produce	PhD
William	62	Male	soybean	BS
Jackson	65	Male	soybean/ corn	BA
Charles	59	Male	soybean/livestock	HS
John	69	Male	Soybean	HS
Levi	71	Male	Livestock	BS
Jeffrey*	64	Male	soybean/corn/produce	HS
Mary*	59	Female	soybean/ corn/produce	HS

BS, Bachelor of Science; HS, Highschool Degree; PhD, Doctor of Philosophy, PhD, and BA, Bachelor of Arts.
**participants are married.*

Once all procedures had been clarified, each participant signed the informed consent form and was given a copy for their records. All interviews were held both at the physical site of each organization's site as well as the homes of participants, which allowed me to gain a deeper understanding of emic views/perspectives (Creswell, 1998). Accommodations were made to use on-site office spaces and meeting rooms to conduct interviews when possible. Interviews averaged from 20 to 65 min in length and resulted in 60 single-spaced pages of transcriptions. Recordings were stored and secured on a password-protected smartphone. Audio data was destroyed 18 months after the completion date. Approval and review of the study were facilitated by the University of Memphis Institutional Review Board in February 2017.

Data Collection

In-depth Interviews

The primary method of data collection was in-depth, semi-structured interviews. The interview protocol consisted of a 10-question semi-structured guide (see **Table 2**). Each interview began by focusing on general meaning and understanding. The second part of the interviews focused on uncovering lived experiences and circumstances. Finally, the interviews concluded with the participants own suggestions for interpretations and solutions.

Fieldnotes

Field notes were recorded continuously throughout the project by AC (including during interviews), emphasizing a reflexive approach (Madison, 2005). He did not keep a schedule or format for field notes; writing consisted of jotting down ideas or

TABLE 2 | Questions from in-depth interview guide.

1. How did you get into farming? (e.g., family business, etc.)
2. How/where do you sell your goods (e.g., farmers markets, etc.)?
3. Tell me about your personal experience as an African-American farmer living in the U.S. South.
4. How would you describe the types of support available for African-American farmers (e.g., support groups, community coalitions)?
5. I am interested in how you perceive the plight of African-American farmers in the contemporary agricultural landscape. Can you tell me about that in your own experience? Are there unique circumstances facing African-American farmers today?
6. Do you feel that racism is still an issue?
   - (If yes): In what ways do you still see racism as a problem?
   - (If no): Why do you feel that racism is no longer an issue?
7. Tell me about the role of land ownership as it pertains to African-American farmers
8. Tell me about the process of receiving government funding for your farms. Is the process different for White farmers? Have you been affected by the recent *Pigford* settlement?
9. I am exploring the role of farming within the African-American community. Do you have any thoughts about the emphasis (or lack thereof) on farming in the African-American community?
10. Is there anything I didn't ask that you would like to tell me?

observations that he found insightful or noteworthy. Throughout data collection, he compiled a total of six hand-written pages.

Coding and Analysis

Data analysis comprised two main steps: first, an inductive thematic analysis using the constant comparison method (Braun and Clarke, 2006; Silverman, 2006); and then, mapping emergent themes onto the core constructs of the CCA. Thematic analysis involves a 6-phase coding process: Phase 1–familiarization with data; Phase 2–generating initial codes; Phase 3–searching for themes; Phase 4–reviewing themes; Phase 5–defining and naming themes; Phase 6–final analysis and write-up of the report (Braun and Clarke, 2006). The primary author (AC) conducted the inductive thematic analysis, ensuring that the emergent themes were determined by the data. The secondary author (AA) reviewed the emergent themes and coded independently to ensure reliability, taking notes of intersections between the emergent themes and CCA. The final result was the identification of two main themes and four sub-themes.

Phases 1 and 2 were used to identify distinct concepts which could be labeled and sorted. Here, we informally grouped concepts that we considered related to the same phenomenon under broad categories (e.g., policy, farmer experiences). During the 3rd and 4th phases, we refined the conceptual categories to include clearly defined properties and definitions. Emergent themes during this stage included infrastructural barriers, inequality, feelings of pessimism, challenges of capital-intensive farming and solutions for change, and emergent sub-themes included education and awareness, buy-in from outside institutions and focus on family. In phases 5 and 6, we continued the process of stratifying related associations which led us to two distinct themes: erasure of the African-American farming tradition/land loss and solutions for change, and four distinct sub-themes: discriminatory practices of the USDA, shifts in community attitudes toward farming, education and awareness and community and family involvement. During this stage, unique sub-themes which were not crossed-referenced in the data by other participants were combined into broader themes and categories or removed altogether (e.g., challenges of capital-intensive farming, buy-in from outside institutions).

After the completion of the thematic analysis, we began the process of mapping the emergent themes onto the CCA conceptual framework. We started by creating operative descriptions of CCA constructs that mirrored our context-specific research setting, using an iterative approach throughout the mapping process (Silverman, 2006). This is important to note because while the CCA offers a uniformed set of constructs, the research-specific meaning of CCA constructs is not fixed, and can only be decided by the unique context of each study setting (MacFarlane and O'Reilly-de Brún, 2012). Thus, we had to merge our data from the thematic analysis and the intended meaning of the CCA constructs to determine related associations, which included a process of breaking down the constructs of the CCA and re-conceptualizing them with reference to our particular study setting (MacFarlane and O'Reilly-de Brún, 2012). These steps allowed us to take an inductive approach to data analysis as opposed to deductively merging data into a priori categories. Using a heuristic approach, we made the following theoretical associations using our sub-themes: (1) discriminatory practices of the USDA–structure; (2) shifts in community attitudes toward farming–culture; (3) education/awareness and (4) community/family involvement—agency.

RESULTS

Two major themes emerged from the thematic analysis: (1) erasure of the African-American farming tradition and land loss; and (2) solutions for change. Based on the core principles of the CCA, below is a presentation of findings that emerged from the interview data.

Erasure of the African-American Farming Tradition and Land Loss

Participants at both research sites described multifarious ways that the African-American farming tradition and land stewardship has been lost over the past several decades, which they described at various levels (e.g., interpersonal, community, structural). Specifically, farmers identified two main examples: (1) discriminatory practices of the USDA; and (2) shifts in community attitudes toward farming.

Discriminatory Practices of the USDA: Structure

The CCA highlights the role of structure in reinforcing disparities, noting that "differentials in outcomes ultimately reside in inequalities in the organization of societies, institutions, and organizations" (Dutta et al., 2013, p. 161). Historically, dominant social and institutional structures have marginalized the African-American farming community while simultaneously appropriating their influence and cultural traditions within the modern agricultural landscape (Hinson and Robinson, 2008). In recent years, the most significant contributor to the decline of African-American farming has been the bureaucratic and discriminatory practices of the USDA (Wood and Ragar, 2012). This was reflected in our interviews, as many of the participants possessed a keen sense of distrust and skepticism toward the USDA and its related policies and practices, referencing several examples of ways that they faced and witnessed discrimination at the structural level. As William (male, 62) asserted, "it wasn't mother nature that discriminated over the Black farmer, it wasn't the insects, it wasn't drought, it wasn't famine, it's discrimination now of the pen." Jackson (male, 65) described in detail the discriminatory tactics used by Department of Agriculture officials:

> Discrimination is a legal term. If you have Black farmer A with 100 acres, and White farmer B with 100 acres, all other things remaining the same, the insects will not discriminate against A or B, the sun will not shine more, the rain will not, so if the Black man is not capable of producing, when at one time we brought him here for no other reason but to produce, now all of a sudden he is not a good producer, now all of a sudden he cannot afford to pay for the tractor, he cannot pay for the chemicals.

Jackson's narrative draws attention to the unequal and racist lending practices of loan allocation from the USDA offices, mainly as it related to the purposeful delaying of loans to prevent optimal crop yields. As many African-American farmers did not possess the proper amount of invested capital to farm on their own, they were solely reliant on the assistance of the USDA to provide them with the necessary equipment and resources to farm. By denying or delaying African-American farmers loans, many farmers could not pay back the adequate monies in time, allowing USDA to seize operations that went into default and control the economic structuring and racial hegemony of the industry. As Jackson put it, "Black farmers were discriminated against, not in the field, but in the banking and the boardroom!" Conversely, USDA awarded White farmers in the same situation larger sums of money. Charles (male, 59) experienced this firsthand while waiting at the USDA office:

> If you miss your opportunity to plant, see it's like with corn, after April 15th, it goes down a bushel a day. And I planted corn in May, you know, waiting to try to get my loan, soybeans the same way. In other words, it takes money. And White folks which were all in the FSA (USDA) office, didn't believe that a Black man should have no more than $10,000 to farm with. But at the same time, when a White farmer come in there he was given 50 or 60 or $100,000!

Other farmers shared stories of being confronted by similar circumstances throughout their career. Though none reported facing drastic consequences (e.g., loan default, land foreclosure), many participants knew of others who experienced such challenges and offered detailed criticisms and reported feelings of anger and resentment toward the USDA. In our field notes, we noted deep tension reflected in the farmer's narratives when discussing experiences with the USDA. Participants felt overtly discriminated against and perceived current USDA policies as purposefully constructed to reinforce social control, maintain status quo relationships, and eradicate the African-American farming tradition while separating African-American farmers from their connection to the land.

William saw USDA discriminatory practices as the main culprit in the historical land loss of the African-American community: "The accumulative effect of discrimination now has allowed us to lose most of the land that we acquired in 1910–we are for all intents and purposes, extinct!" For Levi (male, 71), the implications of USDA discriminatory practices spanned further than the farming community, as he suggested that the USDA was responsible for reinforcing broader disparities among the African-American population. During our conversation, he described what he perceived as hypocrisy in USDA funding policies in that they market USDA-approved products to African-Americans on food stamps, while at the same time denying their ability to grow food and contribute to the agricultural landscape:

> Interestingly enough, the Department of Agriculture provides food stamps to the African-American community, but they won't give the Black farmer a loan to grow the food…so it's not about food. We can buy all of the food, they'll give us all the where-with-all to buy, we just don't want you to grow. Because its competitive, it involves a source of financial independence, a source of wealth. All of the other minority groups come to this country for one reason and one reason only, they can use their skills, their skillsets that they acquired and they perfected for thousands of years. We were brought here for our skillsets, to produce, to grow food… But unfortunately, we were never rewarded for those benefits, not even then and not today.

Levi's narrative addresses the larger thesis in this article by connecting the erasure of African-American farmers directly to wealth disparities within the broader African-American community. By marketing USDA-approved products to African-Americans on food stamps while simultaneously preventing African-American farmers from securing loans, the USDA exacerbated land loss within the African-American community, which has created large disparities in wealth between African-Americans and Whites. Subsequently, these disparities may have contributed to disproportionately poorer diet-related health outcomes among African-Americans, including rates of food insecurity and weight-related comorbidities. The decline of the African-American farming tradition has forced many African-Americans on food stamps to rely on food items produced and distributed by corporate agribusiness supply chains (e.g., commodity crops). Corporate agribusiness is largely dominated by Whites (91%; United States Bureau of Labor Statistics, 2019).

Shifts in Community Attitudes Toward Farming: Culture

Participants suggested that in-group attitudes toward farming among the African-American community have also contributed to the erasure of the African-American farming tradition. In the context of the CCA, culture refers to the local interpretation of values, beliefs, and practices of a group or community (Dutta, 2008). Participants stated that many African-Americans did not see the cultural value of farming and were unwilling to get involved in any capacity. During our interviews, they propositioned several reasons for this paradox, including problematic associations with slavery and sharecropping as well as the general difficulties that come with intensive farm labor. In the excerpt below, Jeffrey (male, 64) shared his thoughts about how African-Americans' troubled agricultural past has influenced attitudes toward farming, particularly among the elderly generation:

> It will probably be the next generation or the next two generations of Blacks, those that have absolutely no history of say, the grievances…We are still hung up over the grievances in agriculture, and so we have not been able to assess the opportunities. So when you say farming in the Black community, those of us who remember what it was like picking cotton, slopping hogs, feeding chickens, there is a little Black box, in our psychic [sic] somewhere, that causes us to shake our head involuntarily.

Located in Jeffrey's narrative is an articulation of the communicative stigma that is connected with slavery and its implications on the African-American farming tradition. By being disconnected from the cultural value of land and the farming process, the African-American community has missed opportunities to gain economic empowerment and preserve their agricultural roots. Gregory (male, 56) shared a similar observation when describing the apprehension of older generations to embrace farming: "We're victims of too narrow of perspective. You can't get beyond the first level of farming, when you think about the drudgery, the pain, the history of it." For Jeffrey and Gregory, the negative portrayals of agriculture among elderly African-Americans has complicated efforts to rethink dominant narratives and reclaim farming traditions.

Participants also shared concerns that young African-Americans were not entering the field to replace the increasingly elderly population of existing farmers, which threatened to disenfranchise the African-American farming community further. Participants levied several possible explanations for this exigency, including a lack of passion or work ethic toward farming, dearth of opportunities and access to resources and lack of family support. The excerpts below highlight some of the responses from participants describing associated challenges of getting the younger generation involved with farming:

> We don't have a chance! I know you got young boys, if you was to say, "well, we got 200 acres right over here, we want you to farm. We gonna give you the money to farm it with," and write him up, some of these young Black fellas would take it. But trying to go start on your own? You'd be better off going to get you a job cause know you ain't gonna do no good on it!
> *Delvin (male, 62)*
> I don't blame them young Black men from trying to farm, cause there ain't no way for him to make a go at it if you can't get the loans to farm it with. And you've got to have 'time loans,' you can't just borrow $50,000 and owe it back right away, you're going to have some time to where you can set up a plan and wait on them to get right. So, you ain't never gonna get no Black farmers here, not in Mississippi!
> *Delvin (male, 62)*
> Young people nowadays, they don't want no part of it. I might as well just be honest. And that comes from the work ethics that you learn when you were young. When I was young, I couldn't wait to get out there to plow a mule, and then I couldn't wait to drive the tractor when daddy bought a tractor. And the families, you had a certain position in that family. In other words, "junior, you do this." If it's nothing but pump the water for the cows. It was a close-knit type thing, you know. But nowadays nobody cares.
> *Lawrence (male, 70).*

The above excerpts capture the multitude of complexities and challenges of passing the farming tradition down to younger African-American farmers. Delvin's narratives, while accounting for the lack of interest on the part of the younger generation, suggest that there are larger structural constraints at play, which may prevent the youth from participating in the industry. For Lawrence, a deep tension was reflected in the overall laissez-faire attitude that he felt many young African-Americans exhibited. Opposite of Delvin's narrative, which attributed root causes of the problem mostly outside of the hands of those affected, he centered his critique at the family structure and the youths themselves for not cultivating the proper work ethic his own family prioritized with him. Both perspectives illustrate the multi-level nature of the exigency.

Participants attributed the main reason for the shift in community attitudes on farming to the lack of family support and passing down of generational knowledge and education, particularly with regards to land ownership. William suggested that this phenomenon first started in the late 1930s, when new industries and job opportunities became available for the first time for African-Americans. "When the alternatives in the Midwest, the North, and the Northeast became available–the war machinery, the automobile industry, the textile industry–Black folks started to move." As more opportunities became available, many African-Americans chose industrial jobs over farming, often selling off their owned land in the process. However, as many of those industries folded or transformed in subsequent decades, many of those same individuals were not able to recover financially. He continued:

> Unfortunately, now that industrialization is waning, we are looking for other opportunities, to plant our feet economically speaking, and the land that we had acquired in 1910, the 15 million acres, is now all of a sudden gone. So there has been this bittersweet push and pull effect. Discrimination was pushing us, but the call to want to go to the bright lights was pulling. So between the pushing and the pulling, we see now that like the polar bear, the ice is melting all around us.

In addition to the "push-pull" effect of economic migration that William described, participants identified overall neglect and a lack of understanding about the value of land as other contributors to the erasure of the African-American farming tradition and intensifying land loss. As asserted by Gregory:

> We have to know what to do with land, we have to own land, we can't lose any more land. We have lost millions of acres by neglect, by being ripped off, by not understanding what the land has to value in our minds.

A primary cause for this as described by participants were the bureaucratic complexities of "heir property." As described above, heir property is fractioned land ownership or partition sales. In most cases, when a landowner died, the property was passed down to the landowner's children through the formal process of creating a will. However, with heir property, the land was handed down informally where it was held in common, making it difficult to determine who the legal owners were after several generations. As many African-American families migrated to different parts of the U.S. to seek better opportunities, many lost interest in owning their share of partitioned land and would sell their share back to the government. The millions of acres lost by neglect that Gregory refers to draws attention to the disparities in wealth that heir property has created for the African-American community. He provided an analogy in the excerpt below:

> People look at "big daddy" and "big momma" sweated for 40 years to pay for 200 acres, and they cultivated 75 of it. And the kids are now living in LA, Houston and Dallas, Atlanta, go back home and say "all they got on there is that ground where they used to grow cotton, I don't want no more of that!" And then they got about 150 acres of woods, all of them trees and grass,

> what do I need with that? They don't understand! They may be going home and looking at that home site… and they could be standing on three million dollars… If they just understood what they had. Ownership is essential to our forward progress. We've got to educate, and teach ourselves not to marginalize what we have and what our possibilities are, and it starts with that farm!

Solutions for Change

In addition to discussing the multitude of cultural barriers which contributed to the erasure of the African-American farming tradition over the past several decades, participants also noted various solutions to address the crisis. Farmers described two main solutions: (1) education and awareness; and (2) community and family involvement.

Education and Awareness: Agency

One of the central tenets of the CCA is agency. Here, agency is defined as "the capacity of cultural members to enact their choices and to participate actively in negotiating the structures within which they find themselves" (Dutta, 2008, p. 7). Within the CCA, the concept of agency becomes significant as it manifests "in a particular cultural context where community-centered meanings are exchanged, constructed and reconstructed." (Dillon and Basu, 2013, p. 127). By privileging the subaltern voice in both the identification of problems and in the articulation of relevant solutions, the CCA allowed participants to communicate their needs better and provide a more authentic representation of their lived realities. Participants described education and awareness as a main solution to address the African-American farming crisis, positing the inherent lack of understanding of the opportunities that farming offered as the main barrier to generating interest in farming in African-American communities. Participants highlighted concerns such as mismanaged land ownership, unfamiliarity with technology, and close-mindedness as root causes for the problem. Referencing the strategies of previous generations, Keith (male, 60) pointed to the various social and political benefits that land ownership affords individuals and communities:

> One thing that our ancestors did was they went and they got land! If it was the worst piece of land in the world, they went and they got land. You have to have land, and that land presented them with a set of opportunities, the ability to own, to produce, to sell the legitimacy of getting into the system, that's what is so important about land… The land says you have a place where you have your established source of opportunity, security, this is yours, you know? Nobody can violate it, if they do, they do it at their own risk. Having land is really important.

Keith's narrative draws attention to the generational disconnect when it comes to valuing land. Previous generations saw land ownership not only as a way to provide a sense of security, but also as a source of financial freedom, which he suggests may offer similar opportunities to generate wealth and break cycles of poverty and disenfranchisement among current generations. When addressing potential solutions to mitigate land loss and increase interest in farming, Gregory discussed the importance of being educated on potential business opportunities:

> Well, I think one thing, if you are going to have a thriving society, the key to it is education. And I think that right now, where Black people are positioned, is that they need to be educated about the opportunity and benefits of broadening their perspective. You never know, that from that farm, from that one soybean, comes 1,000 variations. And each one of those variations is another market, another economic opportunity for someone. And jobs, and everything else. We have to be educated… Once we become educated, possibilities become tremendous!

As described above, as farming has shifted toward more capital-intensive forms of mechanization and equipment, African-American participation in the agricultural landscape has waned. To become reintegrated into the industry, participants discussed the importance of understanding the role of technology in agriculture to have a better chance of succeeding in the mechanized farming world of today. Though this sample of participants had enough economic capital to stay up to date with current farming practices, they shared strong opinions about how contemporary agribusiness had affected the state of African-American farming and what solutions could be levied. During a conversation with William, he elucidated how the landscape of farming had changed in recent years, and how the overall lack of education and entrepreneurial know-how was negatively affecting the African-American community:

> When we start talking about farming, most Black folk don't know that we use tractors now with the GPS satellite system. You see how straight those rows are? (points to the screen) That deal right there is in tune with 24 satellites, that guy (the driver) doesn't even have his hand on the wheel. But now, the Black community doesn't know that… So, we have not developed an appreciation for the new or the advent of agriculture and the technological advantages, to where we are willing to say "let's go back and look at this new industry."

Community and Family Involvement: Agency

Moreover, in addition to education and awareness, other participants articulated the fundamental importance of getting excited about farming and getting the community more involved and interested. With the growing popularity of direct-to-consumer networks and increased consumer consciousness supporting local farmers, many farmers felt that there were still many opportunities available for African-American farmers to have success. Jesse (male, 52) mentioned the importance of creating bottom-up solutions to get community buy-in to change the existing paradigm:

> We need a groundswell, I think. You need to create an interest for going into farming, and then putting some support measures in place, where mentoring or land access or favorable turns for loans to get some of these young people to see farming as an opportunity. And I think in the future, a lot of new converts into farming, it's not a problem getting African-Americans and other minority groups into agriculture, but the cost of farming, when we look at that sector alone, that is what the problem is.

Expanding on his solution of creating bottom-up solutions, Jesse highlighted the importance of reintegrating the African-American family in the structuring of farm enterprises and getting young families involved early in the process of farming. As described by previous participants, as older African-American farmers continue to exit the business, new generations are not replacing the farmers at an adequate rate. In the excerpt below, he mentions the integral role that young adult African-Americans can play in helping to maintain and revive the African-American farming tradition.

> There are a lot of different approaches, but I think what is similar in all of the approaches is to keep the family engaged in farming. Right? And so, to overcome the Black farming population, the people in their 30s that are interested in doing it have to keep their kids engaged in doing it. And build another generation of people that farm. I don't see any other way short of that to do it.

Further, to address potential structural and cultural barriers that come with generating start-up farming businesses among African-American youth, Jesse again referenced the integral role of family in supporting such ventures. Below he highlights alternative solutions such as creating small-scale, direct market outlets that center on selling directly to family networks:

> By showing young Black kids how to make money from farming, from producing vegetables—like if you have a market garden in the city, I think that young people should be able to market. Maybe—and it doesn't have to be coming to a farmers market, but that's one of the ways that they can do it. I think that a young Black child could sell vegetables, get a commitment from their families, if they have a good family structure, not a nuclear family, but the aunts and the uncles and the grandmas and all of that to buy from them. I think that can be done.

DISCUSSION

In this qualitative study, we applied a culture-centered framework to reveal some of the unique lived experiences and perspectives of a small cohort of African-American farmers in the U.S. Mid-South and drew attention to the role of critical methods as an innovative approach to addressing the African-American farming crisis. The experiences of participants were encompassed by two themes, which were the following (1) erasure of the African-American farming tradition and land loss; and (2) solutions to change.

Gilbert et al. (2002) attributed African-American farm and land loss to the forced sales due to "heir property," lack of access to government programs, and continuing racial discrimination by lenders and government agencies. Similarly, Green et al. (2011) stated that the plantation political economy, sharecropping systems, limits on civil rights and discrimination by the USDA were responsible for the decline. The congruence of grievances between farmers across studies and from many different regions of the United States suggest that discriminatory policies and a social and economic climate may have prevented African American farmers from thriving in America, which implies that solutions to address this crisis should inolve system-level changes.

However, despite the structural challenges African-American farmers face, farmers cited education, and awareness as an entry point to address the crisis. While farmers drew attention to larger-scale barriers such as the unequal and racist lending practices of loan allocation from the USDA, the solutions that they proposed centered on rhetorics of empowerment and self-sustainability and were located exclusively at the community and individual levels. This highlights a level of dissonance between how farmers perceived the crisis and how they felt compelled to act on it. Research highlighting material and symbolic forms of empowerment and individual-level solutions for change among the African-American farming community has been well documented (Balvanz et al., 2011; Fiskio et al., 2016; Touzeau, 2019). While these previous studies highlighted the crucial role of community and individual-level solutions in addressing the crisis, for widespread social change it is imperative to shift the broader conversation to more structural level interventions (e.g., federal loan reform, farm subsidy programs). More importantly, it is critical to gain the confidence of African-American farmers, who have traditionally been self-reliant—perhaps based on their justified distrust and disillusionment of the system—to participate in such reform efforts. Approaches such as the CCA, with its focus on grassroots organizing and collective agency, can serve an integral role in facilitating such endeavors.

IMPLICATIONS FOR PUBLIC HEALTH SCHOLARS AND PRACTITIONERS

We asserted in this paper that the erasure of the African-American farming tradition within mainstream discourses created communication inequities that disenfranchise the African-American community and may reinforce health disparities among this population. Previous critical health communication scholarship similarly drew attention to the role of communication as an enabler of exploitation (Acharya and Dutta, 2012), stigmatization (Newman et al., 2014) and marginalization (de Souza, 2009) in health contexts. However, because our research questions targeted broader cultural and structural barriers and legacies of racism and discrimination, we were unable to make explicit associations between the erasure of African-American farming and population-level health disparities. Nonetheless, our findings (e.g., participant responses regarding land loss and wealth disparities) do present unique entry points for public health professionals to conceptualize these disparities in a broader context. Below we provide several examples of how practitioners might expand their scope of assessment when addressing diet-related health issues, particularly within low-income communities and communities of color.

One way that practitioners can think about addressing diet-related health disparities in is by highlighting the importance of including farmers of color in health-promoting initiatives such as the AFM. Previous scholarship has highlighted the multitude of benefits of AFM, particularly in the context of community-level food access, an issue that disproportionately affects low-income communities and communities of color (Goodman et al., 2012). Despite these benefits, ample evidence has documented that many of these communities are not participating in the movement (Slocum, 2007; Agyeman and Alkon, 2011). For public health professionals, exploring aspects such as spatial geography and the role of institutional cultures in encouraging African-American farmers to participate in the movement may improve diet-related health outcomes in these communities. Examples might include culture-centered outreach efforts to African-American farmers, provision and subsidy programs to help alleviate financial barriers to participation and calls for more diverse management and leadership positions within these spaces.

Another way that practitioners might expand their scope of assessment in addressing diet-related disparities is by incorporating ways to address the cultural erasure and re-appropriation of the African-American farming tradition and related practices, particularly in the organic farming movement. Past studies have drawn attention to the implicit Whiteness in the production, distribution, and consumption of organic food (Guthman, 2014). As the philosophies and values of the movement have shifted away from the influences of traditional African practices in recent decades, much of the African-American community may not be able to identify with the movement's revisionist roots and feel excluded from participation. By working to complicate this narrative and de-center the movement's implicit attachment to Whiteness may provide public health professionals an entry point to better address diet-related disparities within communities of color. Examples might include more inclusive imagery and representation in marketing and promotional materials (e.g., food conferences, farm tourism, community-supported agriculture stores), efforts to promote preservation and acknowledgment of African-American contributions to the movement (e.g., key individuals, moments) and rethinking dominant narratives about organic farming in the U.S.

Lastly, public health professionals can expand their scope by addressing the important role of maintaining and preserving land ownership among communities of color. A primary grievance in the narratives was the lack of education on the part of the African-American community when it came to owning and preserving land, which has resulted in them losing nearly 15 million acres since 1910–and subsequently, much of their political, social and economic power. From an ecological perspective, land ownership has been shown to posit several benefits, including generational wealth, food security, and political autonomy (Chowa, 2007; Binder and Binder, 2016; Pfeffer and Killewald, 2017). Over time, encouraging land ownership may contribute to a reduction in wealth disparities among these communities.

METHODOLOGICAL CONTRIBUTIONS OF THE CCA

The CCA is uniquely situated to address components of the African-American farming crisis. Dominant discourses observing this phenomena are centered on exploring historical timelines using top-down, evidence-based data such as census tracts, policy documents and government reports, and therefore do not reveal the perspectives of African-American farmers themselves (Reynolds, 2002; USDA NASS., 2017;). By de-normalizing dominant narratives and highlighting alternative paradigms, privileging non-traditional forms of resistance by challenging norms and taken-for-granted assumptions and engaging broader structures of erasure and oppression, the CCA adds to understandings of how African-Americans farmers describe barriers (e.g., legacies of racism and discrimination) and opportunities for farming in the modern landscape.

The CCA has been used by other scholars to address diet-related health disparities among marginalized populations (see Koenig et al., 2012; Dutta and Jamil, 2013; Dutta et al., 2016), however this study is the first to take an inductive approach to map emergent themes onto the core constructs of CCA. Employing this two-step strategy to our data analysis was beneficial in several ways. To begin, because our study was not focused on making explicit connections to health (e.g., studying the effects of discrimination on farmer's health), we had apprehensions about applying the CCA as an a priori conceptual model. Having the freedom to create operative descriptions of CCA constructs that mirrored our context-specific research setting and apply them as they emerged across the data allowed us to resolve some of the ambiguity we felt selecting categories during the thematic analysis. This freedom also allowed us to make clearer and more accurate connections between the participant's narratives and broader health disparities.

LIMITATIONS AND CONCLUSION

This study has several limitations. First, the sample size was small and regionally homogenous. A larger and geographically diverse sample of African-American farmers would allow for broader and more nuanced analysis. Additional studies that include farmers from these locations would provide stronger evidence and more nuanced findings. Second, the study comprised mainly of older farmers. Due to the array of documented challenges that younger African-American farmers face, including these perspectives would provide a deeper and more accurate contextual narrative. Also, there remain unexplored dynamics of African-American farming, such as how the recent trend of immigrant farm labor has affected current African-American farmers. Future research in this area should seek to incorporate these concepts.

In conclusion, this study is significant because it contributes new knowledge to scholarship on the African-American farming crisis. Historically, the foundations of agriculture in the U.S. have been built on the skill and expertise of African-American farmers. Initially brought over in the slave trade in the early 1600s, African-American farmers supplied not only the manpower, but a unique skill set to farming that White landowners did not possess (Littlefield, 1981). Unfortunately, as time has gone on, African-Americans have not been properly recognized for their contributions to the agricultural landscape, which has had several deleterious effects for the African-American community, including disparities in wealth, rates of poverty and food insecurity.

Over time, this combination of effects have led many public health programs to target African-American communities for healthy food campaigns aimed at alleviating the associated economic and health-related costs of diet-related health disparities. However, many of these programs do not go far enough in their intervention efforts, often addressing surface-level symptoms instead of systemic root causes. If public health professionals and policymakers are to be committed to establishing health equity among marginalized sectors of society, it is essential that they listen to these narratives of discrimination, struggle and meaning-making and work collaboratively with African-American farmers and communities in seeking spaces for structural transformation toward addressing land loss and health inequality. In this paper, using the CCA allowed us to critique dominant narratives about the legacy of African-American farming, connecting the erasure of African-American farming to the broader context of wealth disparities.

DATA AVAILABILITY STATEMENT

The datasets for this article are not publicly available because of participant privacy. Access to data can be made available upon request. Inquiries should be directed to Andrew Carter, andrew.carter@sjsu.edu.

ETHICS STATEMENT

Jessica McMorris, Beverly Jacobik—University of Memphis IRB board. To participate in the study, individuals had to self-report as Black or African-American, own or work on a farm for over 1 year in the Mid-South (e.g., Arkansas, Mississippi, or Tennessee area), and be over 18 years of age.

AUTHOR CONTRIBUTIONS

AC drafted all major sections of the manuscript. AA assisted with revisions and structuring of the manuscript.

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Navigating Publishing Critical Health Communication Research

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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.

Keywords: critical, publishing, health communication, scholarship, marginalization

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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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A Critical Reflexive Account From Participatory Theater With Asylum Seekers: Lessons for Framing Trauma and Resilience in Refugee Status Determination

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Critical Health Communication scholars can play a significant role in the asylum seeking process by expanding the legal understanding of migrant trauma. Legal processes like Refugee Status Determination (RSD) define the course of an asylum seeker's life. Legal determinations hinge on the persuasiveness of narratives of persecution to decide on the legitimacy of asylum claims. Participatory methods, such as participatory theater, either support or resist legal processes by drawing on narratives of trauma or community engagement, respectively. Methods that rely on trauma narratives validate notions of individual suffering, while methods that use community engagement address the social and communal dimensions of health, including isolation. This essay develops a critical, reflexive account of my situated practices as a theater practitioner working with asylum seekers, and later, as a character reference for my participants' legal claim. I show how participatory projects focusing exclusively on promoting migrant resilience through participation can fail to engage with the power that RSD has to determine the course of migrant lives. Importantly, the legal framework of RSD frames an asylum seeker's every move through the lens of persecution and trauma. As my critical reflections demonstrate, participatory practitioners working with asylum seekers must be aware of how the goals of their engagement may interact with the limitations of the legal process. Such awareness demands strategic forms of engagement aimed at shaping the legal understanding of migrant trauma and persecution.

Keywords: reflexivity, asylum seekers, refugees, trauma, resilience, performance studies, refugee status determination

INTRODUCTION: MOTIVATION AND PROBLEM

What does it mean to be a "true" refugee? Sparking countless debates over several decades, the word "refugee" is one of the most fraught and contested terms of the new millennia. Most nation-states have continued to define the refugee in terms of political persecution. However, critics argue that the narrow legal definition of the refugee, and its even narrower implementation, calls for a radical rethinking of the legal category. The notion of trauma is closely stitched into the cultural and legal understanding of political persecution. Legal processes like Refugee Status Determination (RSD) rely on the production of trauma, while activists, artists, and community practitioners argue that refugees are "more than their trauma." Caught between competing discourses of trauma, resilience, persecution, and freedom, I argue that community practitioners, like those working in health communication, must critically reflect on how legal structures depend on refugee trauma, including medical diagnoses of post-traumatic stress disorder (PTSD), even if they have good reasons for disengaging from it.

Within a contemporary "culture of disbelief" (Gibson, 2013; Jubany, 2017) that treats the testimonies of asylum seekers as false, PTSD is often deployed as a strategy to validate the suffering of asylum seekers (Ticktin, 2011; Pestre, 2012; Willen, 2012). In particular, North American and European immigration courts rely on diagnoses and discourses of trauma as a way to legitimize the political persecution of refugees (Ticktin, 2011; Pestre, 2012; Willen, 2012). The existing literature in refugee health communication focuses on the development and evaluation of targeted and tailored health messages to improve migrant health. It does not consider how the taken-for-granted nature of illness (Lupton, 1994), like refugee trauma, is reproduced in the expectations of legal professionals like immigration judges and lawyers. That is, asylum seekers who fail to meet the law's narrow definition of persecution through the language of trauma and diagnoses of PTSD are unlikely to be successful in their asylum claims. Engaging with the power of courts to shape refugee identity and health, I follow others (Lupton, 1994; Zoller and Kline, 2008; Dutta, 2010) in arguing that Critical Health Communication (CHC) practice must expand its focus from illness-affected populations to include systemic players.

Health communication scholarship has been comparatively slow to address the health of refugees and asylum seekers. Searching "refugee" in *The Journal of Health Communication* and *The Health Communication Journal* yields a mere 36 results, while searching "asylum seeker" yields zero. However, the fascination with refugee trauma is reflected in research funding schemes. For example, the National Institute of Mental Health (NIMH) has funded 26 projects in the 2018–2019 fiscal year containing the word "refugee" in the abstract. More than a third of these projects were studying refugee trauma in some form, while the remaining results were focused on HIV or diabetes. This suggests that of the limited health research on refugees, a large portion focuses on their trauma. In addition to creating troubling standards of health and illness for migrants seeking asylum, it also places indirect pressures on practitioners and researchers who work with refugees and asylum seekers. An underlying assumption of refugee trauma informs the work of many community practitioners.

Some scholars have espoused a counter-narrative of refugee resilience (Coleman, 2012; Simich and Andermann, 2014). Challenging the ubiquity of trauma, proponents of the refugee resilience perspective argue that "[t]hough challenging to survive under [severe] circumstances, many refugees do survive in their adopted lands, and many even thrive" (Simich and Andermann, 2014, p. 2). The cultural discourses and expectations of the trauma/ resilience dichotomy comes to influence asylum seekers through the people who mediate their interactions with social, communal, and legal structures. This includes the work of lawyers and social workers. It can also include the work of researchers and community participatory practitioners.

In this critical, reflexive account, I reflect on my role as a theater practitioner working with asylum seekers, and later, as a character reference for my participants' legal claim. Departing from participatory theater projects that focus predominantly on promoting migrant resilience and addressing social isolation, I engage with the structural conditions of Refugee Status Determination (RSD). In RSD, an asylum seeker's life narrative is weighed on a scale of persecution and trauma. I conclude that participatory practitioners, like CHC scholars working with asylum seekers, must negotiate the goals of promoting resilience while setting up their participants to succeed within the narrow legal definitions of RSD. This involves responding to and shaping the legal understanding of migrant trauma and persecution.

BUREAUCRATIC PERFORMANCE: SHIFTING FROM REFUGEE TRAUMA TO LEGAL EXPECTATIONS

RSD requires asylum seekers to perform their persecution (Jeffers, 2008; Wake, 2013; Cox, 2014). This means that asylum seekers are not only responsible for dictating their narratives of persecution but, more importantly, of *convincing* the judges of their persecution. Alison Jeffers calls this, "bureaucratic performance": "Asylum seekers whose stories have *not* persuaded the authorities of their authenticity have been unable to perform to the required standard and stand accused of being unconvincing in the bureaucratic performance of those stories" (Jeffers, 2008, p.217). For Jeffers, bureaucratic performance takes place within the legal structures of immigration courts and hearings. Within these courtrooms, an asylum seeker's personal testimonial is central to the claim of persecution. Often, these narratives of persecution rely on the language of trauma and evidence of post-traumatic stress disorder (PTSD) to make a convincing case. In other words, bureaucratic performance conceives of immigration judges as *audience members* in the performance of trauma.

Analyzing refugee trauma through a lens of performance studies shifts our understanding of trauma as a condition that is inherent to refugees to a condition that has been established through a series of repeated acts for audiences. This brings up questions of who is considered an authentic refugee, what is considered to be authentic trauma, and who is allowed to decide. The repetition and reliance on trauma narratives in immigration courts suggests that immigration judges find narratives of trauma to be compelling evidence of persecution. Shifting the focus of analysis from migrant trauma to expectations of trauma enables us to see how performances of trauma are coerced from migrants in RSD to convince a legal audience. To address the systemic determinants of migrant health, I contend that critical health communication strategy needs to expand its intended audience from the illness-afflicted population, migrants, to systemic power players, like immigration judges and lawyers.

DISCUSSION

Participatory Theater Practice and Social Expectations of Trauma

The following reflexive case study highlights the tensions that arise when theater practitioners attempt to address the health concerns of asylum seekers by focusing on social well-being and community engagement. As I illustrate, the legal process of RSD frames the social engagement and well-being of asylum seekers as contradictory to their status as vulnerable and persecuted people. I draw on my embodied reflections to illustrate how practitioners can use discourses of trauma and resilience to expand the legal expectations of trauma elicited by bureaucratic performance.

Several years ago, I was involved in a community theater project in a country from the Global North. To protect the identities of my participants, I have omitted the details of my location and the organizations that I worked with. The theater production was a community-supported public project addressing the themes of migration. Consisting of 150 performers, the project involved the performance of stories by and about migrants. My role within the production included facilitating the participation of two young asylum seekers, pseudonymized here as Anisa and Adnan. I met Anisa and Adnan in my capacity as a volunteer at the local refugee aid organization. Volunteers had a number of different responsibilities to facilitate migrant integration. These included running theater workshops (as I did), helping with English skills, engaging them in community activities, attending lawyer's meetings, and helping to fill out legal paperwork. In training, volunteers like me were advised to avoid discussing sensitive or triggering subject matter with migrants. Topics to avoid included conversations about past lives, families back home, or journeys to the host country. In this way, the refugee organization actively resisted the expectations of trauma and persecution demanded by the legal processes of refugee determination— bureaucratic performance. In other words, they attended to trauma survivors by providing opportunities for them to escape from their trauma.

Theater, because of its focus on fun, games, and play, was thought to be one of the best mediums for such an escape. Since I had a performance background, a project manager at the NGO put me in touch with the artistic director of an upcoming community production. I was told that the theater director had approached the organization previously to recruit some migrants for the project. The NGO managers agreed that the play might be a positive, creative outlet for young people and agreed to bring them to the director's acting class to educate amateur actors on the lived experiences of migration. However, the director had little awareness of how to broach the topic of migrant lives. According to the managers, the group of young migrants, who were usually very chatty, were quiet and uncomfortable when they were asked to talk about their lives. The meeting was considered unsuccessful.

The NGO managers thought that I might be able to facilitate a collaboration between the theater and their organization. At our first meeting, the director explained to me, "what theater can do is help us empathize with refugees. We've all felt pain, we've all felt loss." The director wasn't alone. Theater with and about refugees is premised on the "authenticity" factor (Jeffers, 2008; Wake, 2013; Cox, 2014). The "true" or "genuine" or "real" stories of asylum seekers are assumed to foster a sense of connection with the theater audience. And as witnesses to someone else's pain, audiences are supposed to feel empathy. What is left out of the narrative of "empathizing with refugees" is that the power to determine the authenticity of the narrative lies with the audience. Just like in bureaucratic performances, where refugee characters must *convincingly portray* refugee narratives, theater audiences find narratives of trauma most compelling (Jeffers, 2008; Wake, 2013).

The director sought to humanize migrants at a time when they were being demonized by mainstream politicians and press. However, his unsuccessful attempt to involve migrants pointed to the controversial ethics of making migrants uncomfortable by asking them to share painful stories. The default desire to focus on migrant pain brought to life Jeffers' argument that participatory theater practice risks recreating scenes of trauma for migrants who may be actors or audience members. As such, a key lesson for health communication scholars and theater practitioners alike is that performance easily mimics a legal process that understands persecution in terms of trauma. By expecting narratives of trauma, as the director had done, this participatory theater production risked solidifying the legal frameworks determining "authentic" refugee status.

At the same time, involvement in theater and performance can potentially play a significant role in addressing aspects of social isolation and its associated health outcomes. Asylum seekers are barred from a range of communal activities including schooling, college, and work (Thompson and Schechner, 2004; Balfour and Woodrow, 2013). This further prevents them from having access to community events that can help engage their participation in their host cities. Applied theater interventions, like the participatory project that I was involved in, aim to build community and address isolation for improved social and mental health (Conquergood, 1988; Salverson, 2001; Thompson, 2009; Balfour and Woodrow, 2013; Wake, 2013; Cox, 2014). The relevance of these ideals for my participants became apparent as we began to work together. For example, when Adnan found out that I was a theater student at a nearby university, he sought me out immediately. As documented by my field notes (S. Misra, field notes, February 24, 2014), he confided:

> So you're in theater? I'd really like to act. Do you direct? I'm quite good. My sister and I used to always perform back home. We were the stars of our schools. Well, my sister was the smartest student in the entire school. She was always getting awards and flowers. She's a really good writer, so the teachers would ask her to give speeches to motivate the students... And I used to cause trouble, so they asked me why I wasn't like her...

Adnan said all at once. "But I like to be a clown," he smiled widely. "As you saw in the class. So if you ever need anyone for a play, let me know." It was clear from this first interaction that Anisa and Adnan were actively seeking out opportunities to be involved in the community. When I met them, they were volunteering at a food kitchen. This was a different relationship to theater than the one envisioned by the director and typically described in refugee performance literature (Jeffers, 2008; Wake, 2013; Cox, 2014). For

Anisa and Adnan, theater was not a medium through which they could tell their stories– ones that would mimic or expand upon the stories they had to tell in their asylum claims. Instead, theater, like working in the food kitchen, served as a means of connection in the host country and as an opportunity to be recognized for their talent or service, not their vulnerabilities.

Adnan did not simply want to be a clown. He wanted to be a star. Rejecting the preparation we had done over almost 5 weeks, Adnan came to one of our final workshops with a fully developed stand-up routine. "Man, the Italians are so lazy," Adnan crooned in his monolog, "they didn't even finish building the Colosseum! I'm telling you, if you ever need anything built, do not hire an Italian builder…" Inspired by the comics he saw on television, Adnan wanted to entertain and be admired. The day after the production closed, he spent his limited funds traveling to London to audition for the X-Factor. Contrary to the assumptions of the theater director– who believed that theater could produce witnesses for migrant trauma– Anisa and Adnan wanted people to witness their talent.

As we prepared for the production, I did everything I could to steer clear of painful or traumatic subject matter– perhaps too strongly. Once, as I was working with Anisa, I asked her to think of a happy moment. But happiness is often stitched with sadness. The moments that brought Anisa joy, like cooking with her mom or laughing with her brothers, also reminded her of an abusive father. I noticed myself get nervous when Anisa got sad. I had resolved to *not* mimic bureaucratic performances in my theater work. In retrospect, and as I will discuss, my well-intentioned resolve to change topics whenever a conversation got heavy could have compromised Anisa and Adnan's asylum claim. My project was embedded in the bureaucratic process of asylum seeking. By seeking to resist the narratives of trauma in a participatory theater project, I risked going against the expectations of vulnerability and trauma set up by the refugee determination process. Instead, I had to hold the complexity of trauma, resilience, remembering, and forgetting. I had to be strategic— prepared to respond to the legal understanding of persecution.

Participatory Theater Practice and the Legal Expectations of Trauma

Four months after the production had ended, Anisa wrote to me saying that their asylum claim had been rejected. They had decided to appeal the decision and had asked me for references of support. This was not an unreasonable ask. It was expected that volunteers like myself would do what they could to help with an asylum seeker's court case by writing references, communicating with social workers, and attending lawyers' meetings. I wrote back to Anisa, asking what kinds of traits they were looking for. According to the letter from the immigration department, Anisa said they were rejected for reasons that included not being from a priority country and not being of a vulnerable age. The letter also cited that based on their participation in community activities like volunteering at a food kitchen and the theater project, they were deemed to be independent and confident enough to take care of themselves in their home countries.

I approached the NGO project managers for advice. They wrote:

> ...it is good to show local support in this way. I would hope they have approached staff at college and others who can also write letters of support. All it is, is a character reference in a sense... if relevant, you can mention whether this rejection is affecting them adversely and could comment that way. I am not sure what their chances are—somehow, I am not sure that [people of their nationality] are winning their claims (personal communication, August 26, 2014).

This moment shifted how I understood my engagement with my participants. By focusing exclusively on migrant resilience and well-being, I had failed to engage with the legal frameworks and logics of RSD whereby an asylum seeker's every move is analyzed through the lens of persecution and trauma. My audience was not simply the migrants I worked with, but also the courts who interpreted their activities. Recognizing that my role was to help the courts understand that resilience and trauma were not mutually exclusive, I desperately wrote a response to Anisa's request. This time, I framed her confidence and resilience in terms of trauma:

> … In my work with Anisa, I have had indications that her past experiences have severely affected Anisa's life. These things were disclosed to me within the privacy of our workshops during candid reflection when Anisa recollected memories in a stream of consciousness. After occasions like these, I had to provide other distractions so that she could regain control of herself... There is no doubt that Anisa is a dynamic, confident and well-spoken young woman. However, I have reason to believe that these are precisely the qualities that have led to her abuse in the past and are unfortunately, working against her, again… she needs help. She suffers from panic attacks and anxiety. By going back to XXX I believe she will be left to fend for herself against men in her family and community who are abusive and violent. It is for this reason, for her safety, health and future, that I ask you to reconsider your decision of rejecting her asylum claim. As a young woman her life will be put back in danger when she deserves a chance at being the productive asset to a society that she has the potential to be (personal communication, August 27, 2014).

At first, I was uncomfortable writing these letters. I revealed painful details from our conversations. Details that were confidential and not initially meant for public audiences. I consulted the project managers and Anisa and Adnan before sending my letters. Everyone agreed that my documents suited the circumstances and the siblings had been appropriately characterized.

My discomfort stemmed from the initial goal of going against the narratives of trauma that defined refugees within the framework of bureaucratic performance. I knew that Anisa and Adnan, like many young asylum seekers, were more interested in presenting themselves as skillful and talented, instead of persecuted and traumatized. I resisted talking about their past lives and journeys to England and used theater as a tool for social integration and relief. Overcoming countless odds, Anisa and Adnan won their appeal and theater has continued to play a pivotal role in their integration. Over the last 5 years, they have gone on to act in other shows, produce their own plays, and direct scores of other theater enthusiasts.

However, while they were going through the refugee determination process, I realized that the desire to disengage from trauma did not align with expectations of the broader bureaucratic structures. Anisa and Adnan had to provide convincing narratives of vulnerability and replacing those narratives with stories of resilience put them in danger of having their claim rejected. My role as a participatory practitioner required me to respond to and influence a legal understanding of migrant persecution. I had to be strategic in the way I framed Anisa and Adnan's resilience in my letter to the immigration judge.

CONCLUSION

This paper has provided a reflective account of the need for critical health practitioners to consider how the legal frameworks of RSD, and its associated focus on demonstrating trauma, influences the work of practitioners and researchers in profound ways. In particular, my account provides two key insights for participatory forms of research and performance practice with asylum seekers. First, asylum narratives of confidence, well-being, and sound mental health can work against asylum seekers in their legal claims. While I remain critical of the ubiquity of trauma in refugee narratives, I now recognize that participatory projects must reassess their ethical stance toward resisting narratives of migrant trauma. I had good reasons for initially not engaging with Anisa and Adnan's painful experiences. They had made it clear to me that they did not want to victimize themselves. However, when I was asked to write a reference letter for my participants, I had to reassess this ethical stance. Instead, and the second key insight of this account is that resilience can strategically be framed in terms of trauma to attend to the legal expectations of persecution. I used my position as an institutionally affiliated practitioner to influence the legal interpretation of my participants' narratives. If I had clung to narratives of resilience, as I was compelled to do in the theater project, I would have failed to engage with the ways in which the theater project was implicated in the legal structures of RSD. Ultimately, health communication researchers would benefit from an approach that highlights trauma and resilience as interconnected phenomena with differential impacts requiring constant attention to their political efficacy. And, as health communication funding structures may mimic the legal expectations of bureaucratic performance, practitioners and researchers must be reflexive about their approaches.

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

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How to Have (Critical) Method in a Pandemic: Outlining a Culture-Centered Approach to Health Discourse Analysis

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In this elucidative essay, we offer a broad outline of the culture-centered approach to health discourse analysis as a warrant for the relevance of critical health communication amid the global COVID-19 pandemic. While there is a proliferation of methods and approaches to health discourse analysis, we outline one broad approach, based on the theoretical tenets and political commitments of CCA. In particular, we emphasize (a) the heuristic value of the CCA's primary and theoretical components—the matrix of culture, structure, and agency, and (b) the importance of exploring discursive erasure as two central principles that guide analysis within this framework. Given the range and scale of existing and likely future transformations in social, political, and cultural understandings of health in the wake of the global COVID-19 pandemic, we offer, through this "how to" essay, a rationale for the continued relevance of critical health communication.

Keywords: culture-centered approach, critical health communication, critical methods, COVID-19, discourse analysis, health discourses

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Discussions around COVID-19 are bound to shape the future of public health and health communication scholarship for the medium to long term. As the "novelty" of the SARS-CoV2 virus causes irreparable human, social, economic, and political impacts across the globe, critical scholars of health have an ethical responsibility to imagine and prepare for the theoretical and practical implications of a post-COVID world. Even as the global pandemic ensues, there is enough evidence to suggest that the terrains on which we form public consensuses around health, privacy, and security are shifting. Critical health scholarship, and in particular, critical health communication (CHC) is well-positioned to outline the already-unfolding transformations in cultural politics, bio-surveillance, immigration policies, militarization, and securitization under the auspices of public health.

COVID-19, POST-NEOLIBERALISM, AND THE FUTURE OF CRITICAL HEALTH COMMUNICATION

The COVID-19 pandemic, riding on the well-worn trails of global capitalist flows, has, in a matter of months, traveled from a seafood market in Wuhan, China, to more than 210 countries in the world, with a global caseload of more than nine million and counting (as of this writing). While the deep furrows of neoliberal capitalist globalization have undoubtedly accelerated the global spread of the virus, the arrival of the pandemic coincides with the recognition that the neoliberal consensus that has dominated global politics—and thereby global health politics—over the last few decades is giving way to a new political moment. The resurgence of right-wing ideologies across liberal democracies in Europe, Asia, and North America, together with the emergence of an expansionist China as a significant engine of global health politics point to the possibilities that the distinctly neoliberal flavor of global health—nudge economics, privatization of healthcare delivery, the creation of individual health "entrepreneurs" through the charity-based interventions of large private foundations—will give way to new modalities of biopower. Indeed, one needs only look at the public health responses to COVID-19 by governments around the world to see suggestions of the authoritarian turn in global health. Many governments have used the exceptions caused by COVID-19 to push through draconian labor laws, violations of privacy, bio-surveillance, and border closures. More fundamentally, public health responses to COVID-19 have recast decades-old tensions between individual "liberties" and the "common good." Organizations such as Humans Right Watch (Roth, 2020), among others have pointed to specific examples in Thailand, Cambodia, Turkey, Egypt, where ruling governments have chosen to downplay the threat of the virus and censured journalists and/or healthcare activists who have critiqued the government's stance. The U.S. government, like its counterpart in Brazil, has gone to great lengths and a concerted effort to deem the pandemic a "hoax," before the sharp uptick in caseload has led these administrations to change course. U.S. President Donald Trump has even gone on to boast about his closing borders as signals of political muscle-flexing; not to forget the June 2020 government diktat to ban the issuance of work visas, the now-aborted attempt to deport international students taking online classes, and the threats to limit the scope of federal funding for a host of efforts associated with the pandemic, including, but not limited to funding for COVID testing.

Why is this relevant to critical health discourse analysis? It's because we have seen this before. The lessons from the decades of HIV/AIDS politicization should tell us something. Just as governments around the world fine-tuned neoliberal ideologies of public health in the wake of the HIV/AIDS pandemic, COVID-19 is likely to be the template for these new set of transformations. The use of "emerging" or "novel" infections as a pretext for making exceptions—to social safety nets, to preventative healthcare access, testing facilities, labor rights, or to universal healthcare—is an old trope in global public health governance (King, 2002; Leach et al., 2010; Sastry and Dutta, 2013). As Priscilla Wald reminds us, the "outbreak narrative" has a particular political-economical function in creating states of disease exceptionalism (Benton, 2015). In this essay, we offer one approach to thinking about the politics of public health in the post-COVID landscape.

Our title references Paula Treichler's influential essay, "How to have theory in an epidemic: cultural chronicles of AIDS," where she offers a heuristic binary (of the "dual epidemics" of biomedicine and signification) to interpret the maelstrom of meanings that circulate during epidemics. Our goal for this essay is to offer a broad template for the critical scrutiny of health discourses, and what such a method would look like in a post-COVID world. We offer some perspectives on "doing" critical analysis of global health discourses, by looking back—on our respective bodies of work in the area—and looking forward to how COVID-19 will shape critical health communication. Before we elaborate on this dual gesture, though, first, an initial attempt to grasp the notoriously slippery question of what we mean by "discourse," or in this case, our specific term, "global health discourses."

Both our research trajectories have been profoundly shaped by the culture-centered approach (CCA) to health communication, a theoretical turn in the field that has prioritized listening to struggles for health within global margins rather than persuading the marginalized to change their behaviors; local, contextual meanings of health over universal "best practices"; knowledge co-created with marginalized groups around the world over theories tested on student samples at the proverbial "large public university"; and reflexive vulnerability over dispassionate scientism as a core research imperative.

Through our engagement with CCA, we have come across instances where a co-participant or a community member discusses issues of health (or safety, or hunger), through a reference to broad social processes that are elusive to pinpoint in ethnographic work. These broad, intangible processes seem immutably linked to the very fabric of society for the individuals and communities that bear their brunt. Farmer (1996) refers to these elusive processes as *structural violence*—when the very nature of social and political organization in society violates one's ability to survive, thrive or act meaningfully. Structural violence appears in ethnographic interactions as a palimpsest, or an undefined contour, there, but impossible to isolate because of its fundamental relationship to basic social realities in the world. Here's an example to elucidate: in our fieldwork one of us asked *Krishan,* a migrant truck driver in India why they thought long-distance truck drivers are particularly vulnerable to HIV/AIDS. In response, *Krishan* alluded to the rush for bauxite mining in their village in the northern Indian state of Uttar Pradesh, which in turn has significantly hurt the prospects of land ownership or tenancy, making traditional agricultural practices unviable, and which in turn "pushed" them out into trucking in order to provide for their family. This involved migrating to the city, leaving home, being away from their spouse/regular sexual partner, and thus, within their lifeworld, into the domain of HIV risk. Here, the "precarity chains" (Silvey and Parreñas, 2020) are visible in encounter, but not explicit enough for analysis.

In a similar example, *Rimi*, a transgender woman in Omaha, Nebraska in the U.S., who is engaged in sex work, points to how adequate and empathic access to mental health services, and not concerns related to HIV and AIDS, is a critical determinant of health and safety for her, her friends, and colleagues—here again, the connections between mental health, health equity and dignity offer a way to think about HIV/AIDS risk that is not available with functionalist analysis of risk behavior. In another instance, *Royston*, a Barbadian immigrant living in the Midwestern United States may reflect on his attempts to "pass as straight" while seeking to immigrate into the country, for fear of the stigma of HIV. In each of these instances, taken from our work, rich and layered as they are within complex narratives of health, it becomes apparent that there were larger institutional arrangements—often elusive in that they represent the very fabric of societal processes—that directly impinged on their health, even though they may not refer singularly to these arrangements (policies, stigmas, laws, etc.) in particular.

To get to these broad institutional mechanisms, we turned our gaze to potential sites where these arrangements may be more visible. In the first example, the migrant trucker's experiences are a distillation of the increasing forays of global mining conglomerates into mineral-rich rural indigenous communities in India, which are in themselves a result of specific policies crafted into India's developmentalist agenda of resource extraction. For *Rimi* and her colleagues in sex work, structural violence manifests in a cycle—the myriad levels of social, cultural, medical, discursive discrimination for being a transgender first, and then for being engaged in sex work—leading to and due to lack of employment and insurance, lack of social, medical, and institutional support—leading to sex work and mental health issues—in turn feeding into the multiplying layers of stigma and discrimination and violence. Similarly, the last example harkens back to specific policy language that prevented HIV+ individuals from immigrating to the United States (before the passing of the PEPFAR Act in 2003). For Royston, "passing as straight" was necessary to reduce the chances of being asked to produce secondary HIV testing documentation through the immigration process.

When we refer to global health discourses, we mean these broad connections between individual, culturally-rooted experiences of health and how these experiences are materially and symbolically linked to health articulations within broad institutional frameworks (policies, laws, ideologies, cultural productions, media, etc.) Discourse here refers to an entire complex of articulations around health—the sites of articulation, the historical patterning of the articulation, as well as the specific articulation itself. We use the term in concordance with (Reisigl and Wodak, 2015) who characterize discourse as "a cluster of context-dependent semiotic practices that are situated within specific fields of social action" that is socially constituted and socially constitutive" (Reisigl and Wodak, 2015, p. 89) and "related to a macro-topic" (Reisigl and Wodak, 2015, p. 89).

This is admittedly a broad brush to paint with—our work has investigated the ideological underpinnings of such discourses across a diverse genre of texts—from policy articulations like the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) (Sastry and Dutta, 2012, 2013), print news—on the 2014 Ebola epidemic in West Africa (Sastry and Dutta, 2017), and the HIV/AIDS epidemic in India (Sastry and Dutta, 2012), documentary films like "Born into Brothels" (Mendes et al., 2010), the social media content of health institutions (Sastry and Lovari, 2017) and others. While these projects have largely been undertaken independently, or with other authors, we recognized over time that we were converging on a particular mode of reading of health-related texts.

The point is to make the case for a heterodox CCA *methodology* [any process that leads to the "identification of objects of research" (Fairclough, 2013, p. 234)]. We demonstrate that the heuristic value of the CCA lies in conceptualizing objects of research that can be analyzed through different *methods*. We are not as invested in introducing (another) general "method" of discourse analysis of health, as we are in showing how CCA animates *one* way of doing analysis in critical health communication. We see heuristic value in this method and recognize its potential to broaden the set of tools at hand for critical health scholars.

The essay follows thus: we begin with a brief introduction of CCA and its primary and secondary components. We then offer direct and practical ways in which we harness CCA concepts in the service of textual analysis of health discourses. Along the way, we take brief detours to situate this method within existing literature—like critical discourse analysis (Fairclough, 2013), modes of analysis—like the Peircean idea of "abduction" (Timmermans and Tavory, 2012)[1], and debates about ethics in critical analysis—e.g., the role of self-reflexivity vis-à-vis fidelity of interpretations (de Souza, 2019)[2] We offer some examples of this method from within our work, before ending with a discussion on limitations and potential contributions of this kind of scholarship.

CULTURE-CENTERED APPROACH TO HEALTH COMMUNICATION

The culture-centered approach to health communication, as represented by the writings of (Airhihenbuwa, 1995; Dutta-Bergman, 2005; Dutta, 2008; Basu and Dutta, 2009; Sastry et al., 2019), theorizes linkages between culture, health, and marginalization. Originating with the critique of the Eurocentric (e.g., Basu, 2011), individual behavior-change focused (Dutta, 2007), and status-quo (Sastry and Dutta, 2011) traditions of health communication theorizing, the CCA has developed a robust theoretical framework dedicated to a social-change focused vision for health communication theorizing that is developed in co-construction with marginalized communities across the globe (Dutta, 2008).

At its crux, the CCA is invested in how subaltern narratives of health reveal the complex interplay between culture, structure, and agency. *Culture* refers to the gamut of local, dynamic, meaning-making practices around health, while *Structure* refers to the socio-politico-institutional framework or environment within which health is accessed (or denied) for individuals and communities at the margins. *Agency*, an intrinsic human quality, linked to ability, drives human action and purpose

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[1] While we do not have the space to develop it here in full, scholars interested in textual analysis of health in general, and CCA in particular will find (like we did), the large body of literature on critical discourse analysis and abduction relevant. See Fairclough (2013), Reisigl and Wodak (2015), Timmermans and Tavory (2012), and Tracy (2013).

[2] In this collection of articles itself, Rebecca de Souza offers an excellent analysis of broad ethical concerns in doing critical health work. See de Souza (2019).

(such as the quest for health, safety, well-being, food security, etc.) Human agency emerges in response to the characteristics of one's structural environment, and structures themselves respond to human agents. Work in the CCA tradition highlights this constant interplay—or dialectic—between structure and agency in the context of marginalized communities' struggles for health (Sastry et al., 2019). For instance, the nature of structural configurations (trade policies, land ownership patterns, generational poverty, development projects) can affect the livelihoods, safety, well-being and economic prospects of marginalized communities, whose actions to counter and negotiate these structures (migration, high-risk work, contingent employment, leaning on social/cultural others) reveal agency in the face of such structural constraints (Zoller and Sastry, 2016). Culture, defined as local meaning-making practices, offers a vantage point to understand this dialectical relationship between structure and agency. The political impetus of the CCA—as a primarily ethnographic approach to theory-building—is to co-construct solutions to health problems with communities through identifying the interactions of culture, structures, and agency in local contexts.

As one of us has recently argued, the culture-structure-agency tripartite represents a fundamental ontological premise of the CCA (Sastry et al., 2019), ontology being the branch of metatheory concerned with problem definition. As a theory of (health) communication, CCA looks at the dynamic interactions between culture, structure, and agency as the very site of meaning-making around health. This tripartite conceptualization represents the "under the hood" of the CCA: it is a sensitizing mechanism within this form of inquiry, guiding research questions, study design, data collection, and analysis. Articulating health within this matrix allows for questions about what (and whose) articulations of health circulate, and what meanings of health are hidden/missing/erased. This is evident from our respective ethnographic work in the CCA tradition, (e.g., Basu and Dutta, 2009; Basu, 2011; Basu et al., 2016; Sastry, 2016a,b; Sastry et al., 2017). By referring to the culture-structure-agency conceptualization as a sensitizing mechanism, we are recognizing it as an intellectual habitus, or a preferred mode of organizing inquiry that bleeds into our analysis of health discourses in general. This sensitizing framework allows us to ask the critical question: "What voice is missing here?" In other words, we have recognized that the CCA directly shapes "our way" of looking at texts through these two gestures: (a) using the culture-structure-agency matrix as a sensitizing framework, and (b) asking "what is missing from this articulation?" We address each one in turn.

THE CULTURE-STRUCTURE-AGENCY MATRIX AS A SENSITIZING FRAMEWORK

So, what does it mean, in a practical sense, to use the culture-structure-agency conceptualization as a guide to analysis of discourse? In essence, it means using the terms as a broad guideline for *preliminary* categorization/organization of textual data. Put another way, using this framework allows us to look at the interdiscursive connections within a text or a series of texts. Interdiscursivity refers to how discourses within a specific domain of social action relate to, borrow from, or depend on others, from different domains (Reisigl and Wodak, 2015). The C-S-A matrix is a heuristic if often inexact and approximate framework to disassemble and distinguish the discursive claims made in a text, and evaluate the claims against each other. This framework allows us to examine how the meanings of health operating within a specific discursive domain depend on, borrow, colonize (or are in themselves colonization of) discursive claims from other domains.

Within the CCA, *culture* refers to local meaning-making practices around health. When used as a heuristic, we organize all textual articulations about rituals, practices, behaviors, gender norms, barriers, stereotypes, challenges, and so on within the broad umbrella of culture. An alternate approach is to code within the *culture* bucket all *Meso*-level references to health.

Here we are very cognizant (and intentional) in deviating from the orthodox operationalization of culture in the CCA—local, micro, dynamic—and acknowledge the years of painstaking work it has taken to establish (and defend) the precept that people who belong to a culture get to define and name it. Our goal here, however, is analytical, not prescriptive. Our raw, and imprecise categorization is a deliberate strategy against the crystallization of data into an otherwise well-defined concept in the theory, to be open to new, contradictory, and therefore interesting ways in which the data can present itself.

In the same vein, we would use the term *structure* to identify instances of the institutional domain of health. Articulations of policy, trade, population-level data, macro-trends and observations, references to rules, laws, global flows, global governance, etc. are coded under this bucket. Another way of saying it is that all references to the broadest, most macro conceptualizations of health are coded into "structure."

Finally, we take the term *agency* to refer to articulations at the micro or individual level of analysis. All references to individual behaviors, health-seeking, testimonials, first-person narratives, patient non-compliance, individual differences, individual achievements, success stories, are all coded within this bucket. At this stage, we momentarily suspend the political and deliberate valence of how culture, structure, and agency are coded within the CCA—we are not presuming for the moment that all action is "agentic," just as not all behavior is "cultural," and not all violence is "structural."

The matrix provides a viable sensitizing framework to organize and categorize data, in a process akin to "first level coding" (Tracy, 2013) or "open coding" (Corbin and Strauss, 2008) in a qualitative research sense. In other words, we do not categorize the data within a culture-structure-agency matrix for it to neatly fit within our "favorite theory," to use Michael Burawoy's phrase (Timmermans and Tavory, 2012, p. 169). Rather, this categorization *prepares* the ground for us to be *unprepared* by what the data will reveal. To put it yet another way, we do not seek confirmation of the theoretical tenets of CCA through the data in a deductive sense; instead, we use the CCA categorization to find out what is genuinely new, interesting, or contradictory in the data. We think of the CCA as a preferred mode of thinking about health, or an intellectual habitus of familiarity, so that using it to document all that is familiar is a first step toward engaging "imaginative thinking about intriguing findings and then return(ing to the data) to check our conjectures" (Charmaz, 2014, p. 137–138).

Readers will observe that this movement—from data to theory and back—resembles "abductive reasoning" in qualitative research terms or the "inferential creative process of producing new hypotheses and theories based on surprising research evidence." (Timmermans and Tavory, 2012). Abductive reasoning, according to the pragmatic philosopher Charles Sanders Peirce, uses a logic that is different from deduction or induction, and in Pierce's account, precedes them in the logico-scientific process of theory construction. While scholars differ in the primacy they accord to abductive reasoning within textual and/or qualitative analysis, our approach is consistent with that of Timmermans and Tavory (2012), who call for "centering abduction" in analysis. Here's an example from one of our earlier pieces that elaborates this.

In Sastry and Lovari (2017), we write about the Centers for Disease Control's "Disease Detectives" and how the "local cultural expertise" of these public health experts was framed as an exemplar of the CDC–and by synecdoche, the United States' leadership in Ebola prevention. How "local cultural" expertise is defined here is categorically different from how it is conceptualized within the CCA–and yet, coding this data within the "culture" framework allows us to think about the difference meaningfully, ask questions about how this cultural expertise is constructed, and the evidentiary basis for cultural expertise. In this particular case, the fact that disease detectives are invariably American "elite public health sleuths" (Sastry and Lovari, 2017, p. 334) who know the importance of respecting "African culture" (p. 334) opens up the door to asking the important question of missing voices and questioning absences in the discursive space.

Whose Voice Is Missing Here? Voice, Erasure, and the Politics of Representation

As is immediately apparent from the above example, the critique of the "disease detective" discourse hinges on a critical reading of this cultural articulation. Put another way, the critique offers an alternate conceptualization of disease expertise that considers local policymakers, community health workers, health providers, etc., whose work was shown to be crucial in managing the Ebola crises in 2014. Here, this argument was established through the analytical gesture of asking the "Whose voice is missing here?" question. Another example of this is how global HIV prevention interventions targeting commercial sex workers almost always, and universally, advocate the use of condoms and regular blood tests ignoring local cultural perspectives on how health is made sense of and negotiated, leave alone questions on whether HIV is indeed an issue of concern, and if so, what local problem-solutions emerge. These absences in the examples above highlight the concept of "discursive erasure."

Discursive Erasure

As a theory of health communication, one of the primary contributions of CCA has been the emphasis on uncovering "discursive erasure" from the domains of knowledge creation about health. What counts as knowledge, and who gets to create it? Discursive erasure refers to the process of being "written out" of spaces of knowledge creation. Who gets to claim expertise over the other, and based on such expertise, gets to fix the other in the discourse, through knowledge claims about cultures, practices, or beliefs? This emphasis on erasure emerges from CCA's theoretical rooting in Subaltern Studies, which concerned itself with the politics of historiography—the writing of history—and how the histories of the *subaltern*, or the most marginalized sections of society, are written in ways that erase their agency. CCA takes this impetus and applies it to how knowledge claims are made about subaltern groups across the globe, and how the health agendas of such groups are rendered invisible, or irrelevant when compared to the health agendas forwarded by "experts" outside such communities. For example, Basu's (2010) work argues that health interventions targeting sex workers in India need to recognize that sex workers see themselves primarily as mothers providing for their children, and not as a "high-risk" group for HIV/AIDS, as they are often construed within health discourses. The material risks that sex workers undertake are constellated within their role as mothers who provide sustenance and care—a fact that is often erased from the discourse on sex workers.

As a pragmatic step guiding the analysis of health discourses, the "What is missing" question is akin to what Stuart Hall calls an "oppositional reading" of texts—a reading that is based on a suspicion of the fundamental codes within the text. By asking "what is missing," we orient ourselves toward the ideological consensuses that function within the text and seek out alternative ideological possibilities. Having coded texts based on the culture-structure-agency matrix, we now probe about silences, omissions, and erasures. This is, of course, a deeply political act that harbors no pretenses about neutrality on the part of the analyst. Such motivated hermeneutics seeks gaps, omissions, foreclosures from the text in a deliberate, personal sense.

This particular gesture often troubles our colleagues, students, and reviewers. The idea that we ask "what is missing from the discourse?" does not categorically assume that we (or you!) know. This doesn't assume an omniscient analyst, but it does presume that the analyst brings their enacted, embodied, and reflexive lifeworld into considering what is missing. And in this sense, the subjectivity of the analyst does matter. For instance, one of us was recently working with a graduate student on their Masters' thesis project on arsenic poisoning in groundwater in West Bengal, India. Having completed their fieldwork, the student was remarking on the fact that the data they collected was populated exclusively by narratives of male participants and that they did not have any "empirical" data about how rural women felt about arsenic poisoning of village groundwater. As an aside, arsenic poisoning is a geogenic feature of the Gangetic basin, and is occurs naturally in large parts of South-East Asia that are dependent on groundwater. Groundwater wells that are found to be arsenic-laced are often sealed off, meaning that local community members have to rely on alternate sources to collect water for daily use. Often, this means traveling to neighboring villages, or the nearest "clean" groundwater well.

Even though we knew—from cultural context and second-hand experience—that the gendered burden of drawing water falls largely on women within this cultural context and that the burden of sealing off local water wells would change women's lives in different ways than it did the men who shared their stories with us, this argument was looked at very unfavorably by colleagues, thesis committee members, and reviewers since it was not based on "empirical" data. How could we claim that arsenic poisoning exacerbated gender inequities even if we had not "actually heard" women attest to these patterns? Here, the rigid insistence of empiricism in the face of a rather moderate claim—that women's lives are more burdened by arsenic remediation interventions—speak to the precise dilemma at hand. Discursive erasure here occurs not just at the level of participation—the failure to record women's narratives, but at the misplaced empiricist demand for positivist claims by peer reviewers, ostensibly those not from the same cultural context. To analyze on the lines of "what is missing" depends, partially, at least, on the embodied experience of the analyst. In this case, this embodiment is not just the fact that the student shares a common cultural, linguistic, and ethnic context with the participants (even though they diverge in terms of class and socio-economic privileges), but also the fact that our analysis is shaped by our access to decades of ecofeminist literature that attests to the inequities inherent to water collection in India and the global South. Analyst positionality opens up avenues for tracing discursive erasure.

A disclaimer: we are arguing for researcher positionality as a fundamental tool in analysis, but we are *not* suggesting that our—or any—positionality is transcendent. Speaking for the subaltern, or being rendered the "native informant" carries with it the infinite regress of the politics of representation—who can truly speak for the subaltern. Our positionality as particular subjects within a discursive arena is limited: in the thesis example, we don't claim to speak for the women in the villages where the fieldwork was conducted, and we don't claim to have an authentic voice to represent them because we look like, talk like, or claim to think like them. And yet, what we do know about the context from our own lived experiences is not circumstantial, in this case, and is central to the analysis. Analysis in the CCA is based on being reflexive about how the very process of critique of discursive erasure can itself create avenues for further erasure. Just as researcher "common sense" is predicated as a given in constructing research instruments like surveys, or experimental protocols, analysis within the CCA requires attending to the "common sense" that derives from the embodied, reflexive self of the analyst.

CRITICAL HEALTH COMMUNICATION, GLOBAL HEALTH, AND POST-COVID FUTURES

Epidemics are characterized by semiotic excess: they create pathways through which meaning-making processes are transformed and/or accelerated. Critical health communication scholars, invested in exploring how issues of power, control, ideology, and identity shape meaning-making practices in health, look to epidemics as sites of both transformation and reification of existing understandings of health. The COVID-19 pandemic has already led to fundamental transformations, and will continue to foment further transformations in how we understand health. These transformations play out at the "micro" discursive level, for instance, in how the language around health changes. Consider how discursive terms referring to masks, "social distancing," "droplets vs. aerosols," and "flattening the curve" enter the public lexicon and are imbued with political meaning. The rate and scale of Meso-level and macro-level transformations in understandings of individual and public health are staggering. At the level of discourse, this essay outlines a broad methodological framework to analyze the communicative claims that undergird such transformations within a text, a genre of texts, or a bounded topical area.

The point of this essay, as we have said previously, is not necessarily to unveil a "new" approach to analyzing health discourses, but rather to outline one (our) way of apprehending and critiquing the political bases of the claims made within such discourses. This explicit political claim lies at the heart of critical health communication (Lupton, 1994; Zoller and Kline, 2008) which looks at the struggle for health as a fundamental starting point. Whether or not the fallout of the global pandemic has rendered our existing political imaginaries redundant is up for debate (It has certainly led to a renaissance of the long-form journalistic essay that deconstructs the cultural politics of the disease. A plethora of them have emerged in the wake, opening up new avenues for the age-old question of "where (critical) health communication may be found" McKnight, 1988). Consider this meme circulating on Chinese social media in January 2020, in the early days of the epidemic, as news emerged of COVID-cases rising in Lombardy, Italy, and as Italian officials made statements about mandatory lockdown measures and mask use as antithetical to civil liberties: "With quarantine/no human rights //Without quarantine/no humans left." The linguistic quip is undergirded by the recognition that the response to COVID-19 has led to new reckonings, on both the left and right, around issues of globalization, immigration, and surveillance.

Tectonic shifts in public health governance notwithstanding, the continued relevance of critical health communication, and by extension, of the need to critically examine the fundamental assumptions underlying healthcare arrangements is nowhere more apparent than in the abject failures of the United States' response to COVID-19. A growing medical consensus points to the systemic flaws of the private healthcare model espoused in the US, in particular the monopoly capitalist formations that make up critical elements of the US healthcare system that have led to the disproportionately skewed burden of COVID-19 morbidity and mortality in the United States. In comparison, economies with robust public health delivery systems, and in particular those built on socialist premises of public funding and equity in healthcare access have tended to have the best COVID-19 outcomes. The lessons from New Zealand, Vietnam and the Indian state of Kerala (the latter a dramatic exception from the rest of the Indian COVID-19 response) make this amply clear (Dutta et al., 2020). The political economy of healthcare systems has never been more relevant, and critical health communication affords a pathway to interrogate how the health claims undergirding such systems are discursively constructed.

In this essay, we offered a broad outline for interrogating the cultural and social politics of meaning-making in public health, based on our background in the culture-centered approach to health communication. We outline how the broad theoretical movements of the CCA have animated our approach to doing textual analysis in health. We hope that scholars will find this approach productive to analyze the many transformations that are undoubtedly at hand. Moreover, we hope to have shown that while the risks and fallouts of this novel virus are indeed that—novel—so much of its politics has been made apparent by epidemics that preceded it. The need of the hour is to look back as much as it is to look ahead.

AUTHOR CONTRIBUTIONS

The authors jointly conceptualized the article. The article was written collaboratively, with each author adding to existing versions of drafts. The final article was lightly edited for clarity by the first author. All authors contributed to the article and approved the submitted version.

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