CBPR and a multitrack model of development: A critical ethnography of a community-based health communication project.

Jeanette Dillon, Bowling Green State University - Main Campus
Kate Magsamen-Conrad, Bowling Green State University - Main Campus

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CBPR AND A MULTITRACK MODEL OF DEVELOPMENT: A CRITICAL ETHNOGRAPHY OF A COMMUNITY-BASED HEALTH COMMUNICATION PROJECT

Jeanette M. Dillon*
Kate Magsamen-Conrad*
Bowling Green State University

ABSTRACT

Scholars in development communication have called for a more participatory approach in development programs. However, the traditional, generally top-down approach associated with the modernization paradigm still dominates in practice [1]. The mere existence of participatory models has not been enough to move the participatory approach to prominence. Sparks has noticed the discrepancy between theory and practice observing that although the dominant paradigm has been disparaged and the participatory paradigm praised since the 1970s, researchers have been slow to adopt participatory methods [1]. This discrepancy may be because in practice, participation is difficult to manipulate, control, analyze and evaluate. We argue in this chapter that the participatory paradigm, specifically, community-based participatory research (CBPR), can contribute significantly to improving population health as it works in tandem with the dominant paradigm, despite seemingly antithetical epistemologies. To assess this contention, we propose interdisciplinary guidelines synthesizing various participatory approaches, and conduct a longitudinal critical ethnography of a CBPR project in a Midwestern university health communication class, as well as during subsequent student involvement across one year. Ultimately, in this chapter we seek to share lessons learned about CBPR by making connections between health and development communication within a pedagogical and community setting.

Keywords: community-based participatory research, sexual assault, applied communication, development communication, health communication, critical ethnography, participatory paradigm

*Authors’ note: Jeanette M. Dillon is a graduate student in the School of Media and Communication, Bowling Green State University, 302 West Hall, Bowling Green, OH, 43403, phone: (419) 372-8349, fax: (419) 372-0202, jmdillo@bgsu.edu. Kate Magsamen-Conrad is an Assistant Professor in the Department of Communication, Bowling Green State University. Dillon and Magsamen-Conrad contributed equally to this work. Authors would like to acknowledge the campaign work done by Jacquelyn Toberman, Brittany Tompkins, and Megan Wasserman. Special thanks also to Krys Ingman, an undergraduate student at BGSU. This research was supported in part by the Center for Family and Demographic Research, Bowling Green State University, which has core funding from the Eunice Kennedy Shriver National Institute of Child Health and Human Development [R24HD050959].
INTRODUCTION

Scholars purport that the dominant paradigm, also known as the modernization paradigm, does not universally further development [1, 2, 3, 4, 5]. Nevertheless, that paradigm still dominates in practice, according to Sparks, in part because alternative paradigms have not fulfilled their theoretical promises. Following the lead of Mefalopulos, this chapter contends that the participatory paradigm can be successfully implemented in a development initiative, and that it can be used in conjunction with the dominant paradigm [6], especially to inform communication of public health in communities.

In order to enrich academicians, researchers, community leaders, and public health and health care practitioners’ knowledge of evidence-based communication methods and practical solutions to improve community health, this chapter describes a community-based participatory research (CBPR) endeavor and intervention. We explored the interdisciplinary approach of a participatory paradigm implemented within a development initiative in a health communication class at a Midwest university and conducted a critical ethnography of the CBPR project. Specifically, a communication graduate student participated in and studied a team of undergraduate communication students as they developed and launched a campus health communication campaign under the guidance of a health communication scientist and professor. We explored the strengths and weaknesses of development paradigms as part of the ethnography, with a particular emphasis on ascertaining the viability of using an interdisciplinary approach of community participation in praxis. Ultimately, we seek to add to the literature and our understanding of best practices of participatory approaches by making connections between health and development communication within a pedagogical and community setting.

Background

Sparks argues that health communication has long been an important component of development communication [1]. He also argues that it has often been a dimension most likely to adhere to the dominant paradigm. We do not dispute that contention in this chapter. Instead, we posit an example of how the dominant paradigm can be effectively employed in combination with the alternative, participatory paradigm. Like Mefalopulos, we contend that despite, or perhaps because of, the epistemological and methodological differences of the paradigms, neither is universally useless or useful in all situations [6]. Both may be applicable within one development initiative, but it is critical to understand the most logical point at which to draw upon one paradigm or the other. We additionally posit that participatory approaches from several disciplines can be combined to facilitate needed interdisciplinary guidance for practical applications. This is especially true in the context of communicating to improve the health of a population. To that end, a review of the paradigms follows.

Combining Dominant and Participatory Paradigms: Development toward better health

Schramm recognizes that the old paradigm, also known as the modernization or dominant paradigm, has been righteously criticized for many reasons [5]. Often, it was faulted for being tied to growth, particularly economic growth, which led to a traditionalism versus modernity binary that supposed the superiority of urbanization, industrialization, modernization, and exogenous knowledge, over rural, traditional, and folk culture, as well as indigenous knowledge [7]. This attention to growth also promoted the idea that change had to occur in a way that elitists, usually Western men, identified as progressive. Schramm notes that there was no room in the dominant paradigm for alternative ideas about what direction change
could or should take, or that some people may prefer striving for development offering different outcomes than those prescribed by Western elites.

Advocates of the participatory paradigm suggest that the paradigm is a viable alternative to the one that dominated in development for decades. The idea that culture matters, that modernization is not always superior to traditionalism, that the two positions are not mutually exclusive, and that indigenous people who understand the culture and traditions of their community have a role to play in their own development, is the basis of the participatory approach to development. As described by Melkote and Steeves, the approach is viewed as a blend of “endogenous and exogenous elements” [8(p4)] of which local culture is a key component and a source of knowledge and wisdom.

The two paradigms seem diametrically opposed. Mefalopulos agrees that the positions are very different noting that from an epistemological standpoint, the modernization paradigm posits that the researcher must be detached from and remain objective about what is being studied, while the participatory paradigm assumes that the researcher is not detached from the object of study and is an active participant in the investigation [6]. At the methodological level, the dominant paradigm posits a quantitative approach, while the participatory model incorporates both quantitative and qualitative methods. Modes of communication are generally different, too, with the modernization paradigm usually adhering to a monologic, top-down dissemination of information, and the participatory paradigm positing a dialogic model of communication.

Mefalopulos argues that in practice, both approaches could be utilized in one campaign [6]. In what he calls the multitrack model, communication is mostly dialogic throughout the model’s stages, but the model also incorporates monologic communication in later phases, recognizing its efficacy in information dissemination important to development initiatives. Specifically, as participants move from research and assessment, to design, to implementation, and finally to the fourth stage of evaluation, Mefalopulos notes:

The single arrow linking the research phase with the strategy design phase indicates the requirement of always using the dialogic mode at the beginning. From the second phase a number of different approaches in any (or a combination) of the two modes can be applied based on the situation – hence the additional arrows. Monitoring and evaluation, while positioned as the last phase, should also be considered at the start to be effective – as indicated by the peripheral arrows at the top and bottom. [6(p. 73)]

Melkote and Steeves updated the model to allow for development approaches and methods not necessarily explicated by Mefalopulos when he first created the model [4, 8]. They emphasized that progression through the stages is not one way, rather all stages feed into each other. The original model’s flexibility is one of its strengths and part of its design, although modifications cannot be made without understanding how the seemingly contradictory paradigms are meant to be used in combination in order to maintain theoretical consistency. An exploration of approaches viable for each stage follows with particular attention given to participatory approaches, underscoring the understanding that two-way, dialogic communication is considered the grounding force of most models.

Participatory Approaches

There are numerous participatory approaches and terms used to describe them that could inform the initial stages of interdisciplinary guidelines. The participatory approach could prove useful in various applied contexts, including health interventions and classroom settings. Mefalopulos advocates the use of communication research/communication-based assessment (CBA) [6], while others have noted the usefulness of community-based research (CBR), and action research (AR) [12], as well as participatory action research (PAR) [4, 9, 10], participatory rural communication appraisal (PRCA) [4, 11], and community-based
participatory research (CBPR) [12, 13, 14, 15, 16, 17, 18]. The recurring theme for all approaches regardless of terms is active participation of people who might be the target of development, or residents of the community in which an initiative will likely be launched. This approach seems particularly relevant in health and classroom contexts given the often personal nature of the project topic and dissemination of information.

Applied scholars may query the best way to include community participation. Answering that question has been a trial for researchers, academicians, practitioners, and more. Most scholars in development communication advocating for the participatory paradigm, for instance, contend that explorative two-way communication is essential to successful, useful, and respectful development programs. Yet as Mefalopulos points out, not all participation leads to great participant involvement, and therefore, not all participation is as effective as it could be [6]. He explains that passive participation is the least effective because stakeholders are expected to sit quietly as they are informed about development that they did not actively help create, while the desired empowered participation is the most useful because local stakeholders have partnered with communication specialists to create solutions to problems hindering development important to bettering stakeholders' lives.

We explore various participation approaches, then, with the goal of optimizing participation. The multitrack model from which we draw much of our inspiration posits the use of CBA in the initial stages of the model, and therefore, we offer a brief explanation of that approach in the next section. We then describe the CBPR approach and argue that it maintains important elements of CBA useful in health and development campaigns, while additionally offering elements of theory important to a classroom setting [13, 14, 15, 16, 17, 18], two factors we found to be key in our exploration of CBPR within a pedagogical context.

**Communication-based assessment (CBA)**

Mefalopulos posits that the main purpose of a CBA is to “assess the political, social, cultural, and economic environment in which a development initiative is situated, exploring the best options for change” [6(p28)]. He further explicates that as a research approach, the CBA may include qualitative and quantitative methods such as focus groups and surveys to inform the assessment. The opinions, knowledge, and perceptions of stakeholders are actively sought out as they are invited to participate in and not just inform the CBA.

Melkote and Steeves call CBA the field research phase where problems are posed and analyzed [8(p33)]. Involvement of community members who will likely be targeted as part of the development initiative in these early stages is crucial, according to Melkote and Steeves, in uncovering root causes to problems, as well as the risks and opportunities of possible actions and solutions given community resources and needs. Mefalopulos adds that work during the CBA should ultimately help answer the “why,” “what,” and “how much” questions about the situation under investigation with information deemed important by stakeholders actively involved in the process [6].

**Community-based participatory research (CBPR)**

Similar to CBA, CBPR posits active participation by community members in addressing community needs [3, 4, 6, 13, 15, 16, 17, 19]. At the basis of most descriptions of participatory research is that all who participate are equal partners. Unlike the dominant paradigm, an expert from outside the community is not immediately recognized as superior to others because he or she has more knowledge or authority than local stakeholders. Hergenrather et al. emphasize this point by explaining “CBPR emphasizes co-learning, reciprocal transfer of expertise, and sharing of decision-making power” [13(p225)] among all research team members, which generally includes academics, business leaders, and community members who may be affected by the development program being discussed.
Ickes has linked CBPR to Paulo Freire’s ideas of empowerment and education [14]. Known for his theories of liberation education explicated in *Pedagogy of the Oppressed*, Freire posits that people are empowered when they are given the opportunity to understand the knowledge they possess [20]. Ickes argues that CBPR can be seen as a means to that end, particularly in the health communication classroom. Her contention is an extension of one proffered by Wallerstein and Bernstein as they explored a “community and school-based prevention project for adolescents” within a Freirian framework [21(p379)]. As with many explorations of participatory approaches, Ickes offers a multi-phased model to follow in praxis, using Freire’s definition of praxis: “reflection and action upon the world in order to transform it” [20 (p. 51)]. Borrowing from Rhodes and Benfield, Hergenrather et al. also detail stages of CBPR in application that they contend are useful in guiding the entire development process, not just the first stages of a development initiative [13, 22]. Love, too, points out that equitable member involvement is important in CBPR throughout all phases of development including identification of problems, formulating research questions, collecting and analyzing data, implementation of programs, and ongoing analysis [16]. In an effort to inform praxis - and add to the literature connecting health and development communication in the classroom and in the community with the ultimate goal of providing useful, interdisciplinary guidelines for a variety of participatory contexts - a comparison of CBPR approaches and the multitrack model follows.

**Friere, CBPR and an Interdisciplinary approach**

Ickes takes the acronym of *SHOWED* proffered by Wallerstein and Bernstein and places the stages represented into three tiers [14, 21]. The stages of Ickes’ Freirian model ultimately address the questions that SHOWED addresses:

- **[Stage one]** What do we “SEE” here? What is really “Happening”? [Stage two] How does the story relate to “OUR” lives? “WHY” have they become/done this (relate to specific behavior)? [Stage three] How is it possible for the individual to become “EMPOWERED”? What can we “DO” about it? [14(p20)]

Similar to most participatory models, stage one in Ickes’ model emphasizes community participation and information gathering. Stage two and three also contain elements found in the later stages of other models, namely: discussing and addressing problems once defined, and devising an action plan to affect positive change.

As part of their investigation into the efficacy of a community-based health program focusing on persons living with HIV/AIDS, Hergenrather et al. presented a CBPR model for research that seems linear but as with the earlier proposed multitrack model, the authors explain that phases of this model often overlap or recycle when used in a community project [13]. Stages suggest that researchers: 1) Identify research questions, 2) Assess community strengths, assets, and challenges, 3) Define priorities, 4) Develop research and data collection and methodologies, 5) Collect and analyze data, 6) Interpret findings, 7) Disseminate findings, 8) Apply findings to address action” [14(p29)].

A pattern emerges when most models of participation are delineated for purposes of application. It is generally understood that throughout the process, stakeholders will dialogue as they deem necessary. In the initial stages, researchers gather information about a problem or need, and then in following stages use that information to create objectives and possible solutions with the ultimate goal of disseminating information and putting into action a plan that will help the stakeholders’ community. Some models offer more practical advice than others, some explicate theory better than others, and some seem more relevant to research than others. All have at their core, however, active stakeholder participation and respectful dialogue to aid that participation.
We argue that the multitrack model first proffered by Mefalopulos and later updated by Melkote and Steeves [4, 6] not only includes model similarities previously discussed, it is also the most comprehensive in accounting for information dissemination, and monitoring and evaluation critical to better campaign development. Concepts detailed in that model, then, inform our updated guidelines for participatory research found in Table 1. Our goal is to clearly explicate the inclusion of theoretical and research tenets of CBPR within a development framework, and then investigate the viability of the suggestions in different settings. By conflating models that include similar themes but originating from different areas of communication – development, health, and pedagogy – we suggest these guidelines to facilitate communication focused on community participation within various applications.

“Insert Table 1 Here”

Many scholars posit that identifying a framework useful in practice, and incorporating theory and indigenous knowledge is important to successful health and development interventions [4, 6, 13, 14, 15]. We propose that for a participatory paradigm to fulfill its theoretical promise, researchers must be able to apply the theory. We use the suggestions detailed in Table 1 to guide a critical ethnography of the development of a health campaign by and for college students to assess that contention as well as the viability of our guidelines.

METHODS

Critical ethnography is useful in this analysis because like participatory research, it actively incorporates and respects voices beyond the scientist’s [23]. Recognizing the need for participation by people not necessarily considered experts in a given field of study, Vandenberg and Hall argue that throughout the research process, the critical ethnographer must be reflexive and work to build relationships based on reciprocity to counter biases and avoid reinforcing the status quo [24]. Madison agrees as she writes of the dialogic, participatory process that the researcher engages in with community members being studied. Participation is also understood when she acknowledges “the ‘performance’ of critical theory” arguing that critical ethnography is “critical theory in action” [23(p15)]. Madison ties key elements to pedagogy and development communication by adding that the critical ethnographer:

… will use the resources, skills, and privileges available to her to make accessible … the voices and experiences of subjects whose stories are otherwise restrained and out of reach. This means the critical ethnographer contributes to emancipatory knowledge and discourses of social justice. [23(p5)]

There is support in the literature, then, for the use of critical ethnography when studying many topics of research, including the areas of health and development communication. This qualitative approach is additionally offered in counter argument to the idea that health communication, as understood by development communication specialists [1], has been especially quantitative and top-down in nature, and that more enlightened development work should include more dialogic communication elements commonly associated with the participatory paradigm.

Authors include a health communication scientist and professor of the class, and a communication graduate student who was enrolled in the class and served as a team leader for one group of undergraduate students. The communication graduate student participated in and studied via critical ethnography, informed by the interdisciplinary guidelines provided in this chapter, a group of students who developed and launched a campus health communication campaign.
Participants

Spring 2014: 86% (n=19) of the students in the health communication class in Spring 2014 (N=22) were female. The group of undergraduate students that the author/graduate student oversaw and studied was comprised of four white women who focused on an anti-sexual assault health campaign intervention (the Sexual Assault Prevention group). All four were seniors; their average age was 22. Two students had been the victim of sexual assault, one during her college career. One of the students had documented learning disabilities (e.g., ADHD) and was suspected of having severe problems with alcohol abuse. The graduate student was 49 years old, the professor 33 years of age, and both White females.

Fall 2014: Three of the four undergraduate students from the Sexual Assault Prevention group campaign attended three meetings to discuss the viability of continuing the campaign. Two other female students who had been part of the Spring 2014 health communication class but in a different topical project group (one that focused on sleep) attended those meetings, too. One of the two students was African American and a senior; the other was White and a senior. Average age of all was 22.

Spring 2015: 48% of the students (n=29) in the health communication class of Spring 2015 were male. As before, the professor divided the class into groups to facilitate participation in various intervention designs focusing primarily on health issues related to sleep and sexual assault. One group was assigned the same topic of sexual assault prevention that was studied in Spring 2014 and the graduate student continued her ethnography with this group. This group included 5 students: 3 White females, one African American female, one White male. One of the White females was a nontraditional student aged 44. The average age of the other students was 21.

Procedure

The theoretical underpinnings of CBPR informed the professor’s course design as she allowed four graduate students to oversee four small groups of undergraduates studying health communication at a mid-sized Midwestern college in Spring 2014. Students and undergraduates were grouped according to similar weekly schedules to allow more easily for meetings outside of class if necessary. Based on survey results indicating several topics worthy of study on the college’s campus [25, 26], the professor narrowed campaign foci to sexual health and sleep, asking that two of the four groups focus on specific areas within sexual health, and two groups focus on specific areas dealing with sleep behaviors. Groups identified their favorite topics and via class discussion two groups identified as concentrating on sexual health and the other two groups on sleep. The graduate student author oversaw a group investigating sexual health. Over the course of sixteen weeks, the groups studied health communication theory, campaign development, and the influence of mass communication on health while attending group meetings to design and launch theory-based campaigns on their own campus. They also helped create, disseminate, and do some rudimentary analysis of pre-test and post-test surveys. All students provided informed consent for the IRB approved project. Additionally, the graduate student received permission early in the semester from her group members to write a chapter about the group’s experience. For a detailed description of the project, which is called the It’s Your Community Project, see [27].

The professor repeated this procedure with a mix of graduate and undergraduate mentors in Spring 2015. An ad hoc group of undergraduate students from the Spring 2014 semester did some work on the CBPR project during Fall 2014 that was also facilitated by the professor. The group was comprised of volunteers who mostly discussed future directions rather than create actual campaign elements. The graduate student continued her ethnography during all semesters. Although we offer elements of lessons learned over three semesters, we
focus our attention primarily on the Spring 2014 semester and one specific group that we will refer to as the Sexual Assault Prevention group, with a more thorough explanation of that name discussed in our results section.

Analysis

Authors reviewed notes, emails, and texts kept and created during the classroom and group meetings attended by the graduate student to analyze her experience, particularly in terms of the CBPR interdisciplinary guidelines. The graduate student took notes during more than 40 hours of class time and eight hours of meeting time outside of class. We also examined materials created by the Sexual Assault Prevention group, including two PowerPoint presentations, one 22 page group paper, and campaign social networking sites such as Facebook and Instagram. Following the lead of previous researchers such as Faulkner and Mansfield [28], we allowed themes to emerge as we observed and reviewed group communication in which the graduate student co-participated. Tenets of grounded theory guided our overall objective: not to force data to fit into an already developed theory, or in our case, set of guidelines and properties to emerge from data collected that might relate to other categories and properties posited by existing theories [29]. The method is meant to be flexible and reflexive. It is also subjective. Authors discussed developed categories and properties at length in an effort to enhance validity.

The following research questions also informed the study and analysis: Does an updated set of guidelines synthesizing various CBPR approaches prove useful in describing a contemporary participatory classroom project? What does this ethnography suggest about the viability of this approach, particularly for academicians, researchers, community leaders, and public health and health care practitioners interested in building knowledge of evidence-based communication methods and practical solutions to improve community health? Other research questions and observations evolved as we reviewed notes and analyzed our experiences, but as Madison argues, the critical ethnographer must begin with at least one question or the research will be less focused and uncertain [23].

RESULTS

The goal of this study was to help facilitate a participatory approach to research in various applied contexts. Toward that goal we created interdisciplinary guidelines for participatory research (see Table 1). Because of the university setting and classroom health campaign focus of our site, the disciplines we used to inform our guidelines included communication, development, and pedagogy. Authors investigated the viability of these guidelines through a critical ethnography where college students developed health campaigns as a part of coursework that launched on their own campus [27]. Our study indicated support for using the interdisciplinary set of guidelines, with modifications (see Table 2), to facilitate CBPR to positively affect college student health. Utilizing the Sexual Assault Prevention group from Spring 2014 as a central focus, we present data, analyses of notes detailing group member’s actions and words, that evidence the presence of the four stages we described in Table 1 based on models created by Hergenrather et al., Ickes, Mefalopulos, and updates provided by Melkote and Steeves [4, 6, 13, 14]. However, although we discovered evidence of all four stages, we found that our proffered guidelines were not always followed by the group in the order we originally suggested. We note in our results when discrepancies occurred and offer an updated set of guidelines in Table 2 that reflect the results of the analyses. The findings we present below are not meant to be exhaustive or prove the efficacy of our guidelines. We detail these findings in order to continue, and perhaps add to, the discussion of CBPR, especially as it may pertain to applied scholarship, participatory research, and public health and health care practitioners’ knowledge of evidence-based
communication methods and practical solutions to improve community health. We endeavored to be pragmatic, thorough, interdisciplinary, and participatory in developing and testing our guidelines.

“Insert Table 2 Here”

Stage 1: Research and Assessment

Stage 1 (see Table 1) describes how participants research and assess the problem they seek to address. Our analysis revealed that, consistent with the guidelines presented in Table 1, this process involved much discussion that one would categorize as dialogic. Once given the topic of sexual health, the group deliberated over several approaches, including condom and birth control usage, but eventually decided to focus on unwanted sexual advances. Data indicated that on our university’s campus, unwanted sexual advances had increased from 2010 to 2014 for both men and women [25, 26]. The group decided to address the trend of increased reports of sexual assault and to work to solve the problem of unwanted sexual advances. At this point, the group was called various names by members and classmates alike: the anti-rape group, the preventing unwanted sexual assault group, or the sexual assault prevention group. Eventually, members adopted the name of their campaign slogan. For clarity, in this chapter we will continue referring to this group as the Sexual Assault Prevention group.

Also consistent with our guidelines presented in Table 1, in identifying the need and the problem, the Sexual Assault Prevention group correspondingly identified what they were seeing and what they thought was happening. At least two women in the group shared that they had been victims of unwanted sexual advances, evidencing how the problem affected group members directly (e.g., the “O” of “Showed” indicating “our lives”). The Sexual Assault Prevention group assessed community (e.g., campus culture) strengths and challenges as they worked to answer why the trend existed. The group decided that changing cultural norms that relied on the woman to stop sexual advances should be the overall objective. Members wanted to involve men, friends, and bystanders in helping prevent unwanted sexual advances. The Sexual Assault Prevention group brainstormed ideas about how to quickly communicate their desire for community involvement. Early messages included “Protecting her protects you, too,” “Don’t be that guy,” and “Truly strong men don’t hurt women.” Group members discussed how offering sexual harassment training to all students on campus would be one channel efficient in helping stop sexual assault. They also discussed social media as communication channels useful in disseminating their campaign messages.

The Sexual Assault Prevention group diverged from the guidelines presented in Table 1 by not creating monitoring and/or evaluation indicators at this stage, nor identifying research questions. They did not address those indicators and questions until Stage 2. Monologic communication was also very important at this initial stage which was not a mode initially addressed in Stage 1 by Mefalopulos [6], and later by Melkote and Steeves [4]. The professor was very present in this stage particularly as she introduced topics tied to research from which the group eventually drew for inspiration [25, 26]. Her direction laid the foundation for creating evidence- and theory-based campaigns. Thus, within a classroom setting and while focusing on potential health initiatives, we found evidence that top-down communication was present and posit that such monologic communication might be necessary to catalyze theory-driven, evidence-based interventions. We modified our guidelines to reflect this finding (see final updates presented in Table 2).

Stage 2: Strategy and Design
The professor was once again very important in helping the Sexual Assault Prevention group into and through the second stage of strategy and design, in line with expectations of the monologic mode of communication detailed in our interdisciplinary guidelines. She insisted that the Sexual Assault Prevention use at least two health communication theories to address their problems and focus messages because of the nature of the problem (both based in interpersonal communication and in behavior change theory). All class members did in-class activities (e.g., mind maps, review of theory “packets” that previous classes had developed) over several class periods; class content was additionally focused on health communication theories and several class members presented their interpretations of theories based on assigned readings. After much deliberation, the Sexual Assault Prevention group decided to use communication privacy management theory [30], to inform the part of the group’s messaging that would address the issue as a dyad; and the theory of planned behavior [31], and the stages of behavioral change model (also known as the transtheoretical model of health behavior or TTM) [32] to instruct the objective of changing societal norms. Several subsequent group conversations focused on defining social norms in need of change, conversations that would have as easily informed Stage 1 as they did Stage 2. Meaning that each time norms were addressed, a more nuanced understanding of the audience was also addressed, a guideline we first detailed in Stage 1. Norms that the Sexual Assault Prevention group members thought contributed to the problem included “Women are the ones who always have to put the brakes on like guys have no control after a certain point,” “Women always have to be on the defense,” and “We need to make people aware they need to be responsible for stopping unwanted sexual advances and they haven’t been.” Prompted by the professor, the Sexual Assault Prevention group also began discussing what questions they would like to add to a class survey to specifically investigate their research questions. Members decided they really did not know how students on their campus would define unwanted sexual advances or whether students felt that they might be at risk of being victims. Members decided to concentrate their questions on uncovering that information and decided to use open-ended questions to that end. Table 3 details the questions developed. Thus, group members began to assemble information to collect data, evidencing the presence of Stage 2 guidelines suggested in Table 1.

“Insert Table 3 Here”

Also as detailed in the guidelines, group members dialogued as they crafted a tailored message and found the CDC MessageWorks site [33] to be particularly helpful. At the CDC website, members were prompted to create a layout of key information, beginning with a title that members interpreted as the main message. The original working title was “Preventing unwanted sexual advances is everybody’s business.” When asked to define the problem, members referred to the previously discussed survey findings [25, 26] and then outlined their campaign goals as prompted. Group goals were to decrease unwanted sexual advances, build awareness that a problem existed on campus, ensure that other students understood that there are multiple people responsible for addressing the problem of unwanted sexual advances, and finally, provide resources to help people overcome unwanted sexual advances. With these general goals as the group’s foundation, group members then created measurable objectives. These objectives may also serve as the evaluation and monitoring indicators first suggested in Stage 1:

- By May 2015, increase the number of BGSU students who (1) are aware of their own power to prevent unwanted sexual advances, (2) know what does and does not constitute consent and (3) know where to go for help if an unwanted sexual advance has occurred.
- By May 2015, decrease the number of BGSU students who (1) believe unwanted sexual advances are the sole responsibility of the victim, (2) are not aware of what
does and does not constitute consent and (3) do not know where to go for help once an unwanted sexual advance has occurred.

Once again keeping the target audience (other college students) in mind, the Sexual Assault Prevention group then decided to use both a promotion and prevention orientation, also referred to as gain and loss frames. According to the CDC, gain frames focus on hopes, accomplishments and advancements, while loss frames focus on safety, security and responsibilities [33]. Believing the group’s audience of college students to be both pressured to succeed and avoid failure, while also generally willing to change and experience new things, the Sexual Assault Prevention group imagined a mixture of gain and loss frames would resonate with their community. Within this stage, then, members addressed objectives as proposed by Mefalopulos [6] and Melkote and Steeves [4]. As part of that process, the group also discussed communication approaches (e.g., ways to frame messages and possible social media platforms for dissemination). The Sexual Assault Prevention group informally discussed a work plan as each group member was assigned tasks to accomplish before launching the campaign.

Our guidelines were also followed as group members joined in class activities involving all of their classmates. For instance, the entire health communication class dialogued about survey questions (all groups had developed some) to more fully understand problems the four groups in the class were addressing, which in the case of the Sexual Assault Prevention group was the increasing instances of unwanted sexual advances on campus. Once survey questions were refined and approved by the professor (see Table 3), all class members distributed the survey (via a Qualtrics link online) as a pre-test of the target community. The professor issued a contest: the group that had the most students on their campus complete the online survey would receive extra credit points. The Sexual Assault Prevention group won the contest. One group member was particularly good at collecting data using a social network strategy; her contacts constituted 75% of the group’s survey total. In great part, then, our proffered guidelines were followed.

The Sexual Assault Prevention group diverged from the guidelines when members did not discuss learning systems or interpret findings beyond those already addressed in Stage 1. Members did discuss learning in general as one group member specifically said “I love learning” as she used the CDC MessageWorks site to hone the group’s message. Additionally, the class conducted pre-test research during this stage, which according to Mefalopulos [6] and Melkote and Steeves [4] would usually be conducted in Stage 3. As before, we modified our guidelines to reflect these findings (see final updates presented in Table 2).

Stage 3: Implementation

Fitting within our interdisciplinary guidelines that suggested the use of both monologic and dialogic communication, the professor was clearly guiding the class and therefore this third stage of implementation. The professor scheduled final campaign presentations with the admonition that campaigns must have been launched for inclusion in those presentations. Dialogue between the Sexual Assault Prevention group members continued as they discussed plans for establishing social networking sites. The same group member who helped the group win the survey contest in the previous stage was also the group member most actively disseminating the group’s campaign message before any media/messaging was officially launched. In an effort to generate content for social media platforms, she contacted various campus organizations to see if they would support the campaign by having a picture taken with poster board signs advocating the prevention of unwanted sexual advances. Recognizing the need to include evidence of individual agency in the group’s campaign, she also asked various students on her campus to, as individuals, hold up one of the group’s signs so that members could post those pictures on the Sexual Assault Prevention social networking sites.
Any group or individual pictured on the group’s sites gave their written consent to be included in the campaign.

The signs that students held reiterated the group’s main message in various ways, and therefore the Sexual Assault Prevention group considered the collection of pictures a soft launch of the campaign. Messages included: “Everyone has the power to prevent unwanted sexual assault,” “My body my rules,” “Alcohol isn’t a green light for unwanted advances,” “Am I asking for it?” and “I thought no meant no.” The group also created a video that additionally reinforced these messages, while also underscoring the central idea that it is everyone’s business to prevent unwanted sexual advances. The group hoped that by personally involving fellow students in the campaign that at the very least, pre-contemplation (an early stage posited by TTM) would occur. The soft launch was more dialogic than the later, more formal launch due to conversations group members had with people creating signs, but technically, given social media’s capabilities, dialogue is continually invited as members communicate on the more monologic campaign sites such as Facebook and Instagram.

The group deviated from the guidelines in Stage 3 by continually revisiting messaging during this stage. They offered details of their logic in a video update that the professor asked each group to create [34]. One member the Sexual Assault Prevention group explained “they were looking to individualize the message” with the poster board signs described earlier and that the “social aspect” was “probably the biggest thing we want to focus on.” They believed the best way to reach and present the target audience with statistics to affect a change in the target community was by video and social media. After a protracted discussion with some Facebook friends, the group decided the slogan of “Everybody [and sometimes “everyone”] has the power to prevent unwanted sexual advances,” needed to be shortened to have more impact online. In keeping with individual agency recognizing bystander involvement, members developed an online presence with the slogan of “Stand Up For Your Body” or “Stand up 4 Your Body” while also including within the discussion on those sites the original slogan of “Everybody [and sometimes “everyone”] has the power to prevent unwanted sexual advances.” The Sexual Assault Prevention group launched their Facebook page on April 14, 2014 [35], and they had a presence on Instagram [36] and Tumbler [37] that same day or shortly thereafter. Members also uploaded their video to YouTube [38] and posted a link to that video on the campaign’s Facebook page. One member wrote the description of the video as “What to do and not to do if a friend is passed out drunk at a party,” a shortened version of explaining that the goal of the video was to show how to interact in a situation in which someone could potentially become a victim of an unwanted sexual advance. The group made an effort to include statistics and resources on all sites hoping to bring about positive change leading to fewer unwanted advances. On the Facebook page, for instance, a short description created by a group member contains few statistics: “This is a college campaign based at Bowling Green State University letting you know that everyone has the Power to prevent unwanted sexual advances.” The long description begins with the following information:

A national survey of nearly 4,500 college women reported in the 2001 "Sexual Victimization of College Women" by the U.S. Department of Justice suggests that many students will encounter sexist and harassing comments, will likely receive an obscene phone call, and will have a good chance of being stalked or of enduring some form of coerced sexual contact

Including that information was not necessarily a dissemination of findings but the Sexual Assault Prevention group followed most guidelines that we proffered for Stage 3.

Stage 4: Monitoring and Evaluation
Monitoring and evaluation began shortly after the launch, aided by analytic capabilities of many social networking sites. By early May of 2014, the Sexual Assault Prevention group’s Facebook page had more than one hundred “likes.” The other social networking sites (Instagram and Tumbler) were not nearly as successful, but members spoke of their value as additional messaging presence online. The health communication class also attempted a post-survey data collection but it was not successful in the context of everything co-occurring at the end of the semester. Students were busy not only launching and presenting their own campaigns, but also completing outside coursework.

After the health communication class ended, most group members left campus for the summer. In August of 2014, member interest in the campaign was renewed when a college athlete was accused of rape. Three Sexual Assault Prevention group members volunteered during Fall 2014 to be a part of a committee to evaluate, monitor and continue the campaign launched in Spring 2014. Two other Spring 2014 health communication classmates (but members of other health campaign groups) also joined the committee and received credit for doing so as part of an independent study with the professor. During that time, the graduate student and professor also met with the university’s health center to discuss a campus-wide launch of the Sexual Assault Prevention group’s campaign. However, the launch faltered when the It’s On Us campaign [39] was announced by President Barack Obama encouraging Title IX universities to launch the bystander anti-sexual assault campaign. The university’s focus became that campaign rather than the campaign of the Sexual Assault Prevention group.

Despite the setback in institutional support for the CBPR campaign, the group continued. In addition to the Spring 2014 data collection, the professor’s research methods collected two waves of data for this project in the Fall of 2014. Students in the research methods class seemingly liked the project because those students comprise about 50% of the current health communication class, which is an elective versus the methods class which is required. The Spring 2015 health communication class will collect data at the end of the semester. Future classes conducted by the professor will continue to use this data to support the evaluation process following campaign launch.

In Spring 2015, the professor began teaching another health communication class, again employing CBPR tenets and interdisciplinary guidelines. In that class, one of the groups of university students is trying to combine the messages of the two campaigns (the CBPR campaign and the national It’s On Us campaign), as well as write a script about preventing unwanted sexual advances to be enacted at freshman orientation. They have decided to continue with a slogan that is a combination of both campaign messages: “Standing Up for Our Bodies: It’s On Us” [40]. They have also decided to use different health communication theories to inform their campaign. Thus, they have returned to Stage 1 as campaign developers, applied researchers, and CBPR participants.

**DISCUSSION**

In general, participatory approaches posit not just participation but equitable participation in the research process by all participants, regardless of status, role, or training. Based on our ethnography of a CBPR project, we argue that equity within a setting in which the primary researcher evaluates others researchers may not be entirely possible but that more equitable learning arrangements can be negotiated when students are invited into the learning, and research process. The professor still held more power than students during the semester yet the professor encouraged autonomy and creativity as she worked to establish criteria that would also allow for student empowerment.

Thus, we argue that active participation by students was achieved in our CBPR project and our guidelines were helpful in clarifying, explaining, and facilitating the process. We modified guidelines to reflect what we learned in our analyses, for example recognizing that some instructions were more present or helpful in stages other than originally designed. Authors of the participatory models that informed our guidelines [4, 6, 13, 14] all spoke of the
permeability of stage boundaries and we found that very much to be the case. Guidelines from one stage often reappeared in other stages. Because we wanted to offer practical advice to others based on our analysis of a CBPR experience, in Table 2, we were specific about which guidelines migrated to various stages.

We also found that combining guidelines from a variety of participatory approaches more thoroughly informed and described our CBPR process than if we had consulted just one model. We contend that scholarship from health and applied communication, development, and pedagogy blends well to guide and inform a participatory project involving college students in research to improve the health of their own community via campaigns and interventions.

Limitations and Future Directions

As with all research endeavors, this project had limitations. One limitation was in the gender and race representation of participants. Only three of the students in the Spring 2014 health communication class were male (14%). All four undergraduate students in the Sexual Assault Prevention group were white females, as were both researchers. Future research should seek to assemble groups that are more diverse. Further, the groups did not include membership from all potential stakeholders. For example, when we had a meeting during the Fall 2014 semester with representatives from across campus, the representatives from the university were uncomfortable with the students having so much power in message creation, and a representative from a local rape crisis center was very opposed to the campaign slogan “Everybody has the power to prevent unwanted sexual advances.” On the other hand, these stakeholders tend to be overrepresented most of the time. Future research could work to determine how to effectively involve more types of stakeholders in a manner that does not inhibit the participatory nature of the project.

Another limitation of the project, not unlike much research, was a lack of resources. Students often paid for materials for the campaign (e.g., poster board) with their own money. One group wanted to create t-shirts but did not have the funds to do so. Authors had made arrangements with the university to move forward with the campaign created in the health communication class at a campus-wide level, but these plans were abandoned in favor of the It’s On Us national campaign (with had monetary support) rather than the campaign of the Sexual Assault Prevention group (which did not). University support was meaningful in creating awareness of the It’s On Us campaign rather than the Stand Up campaign. The It’s On Us campaign was promoted in campus updates and at multiple major sporting events. Not all promotion was positively received, however. An editorial in the campus newspaper criticized the lack of diverse representation in campaign materials, something that may not have been negatively assessed had the university supported the student created Stand Up campaign.

Although participation is difficult to manipulate, control, analyze and evaluate in practice, equitably involving community members in the research process has significant implications for engagement, involvement, and viability. This is especially important in health related research where the goal is often to change unhealthy behaviors or encourage maintenance of healthy behaviors. Future research should continue to apply and modify the guidelines presented in this chapter, especially in different contexts. These guidelines, for instance, may be especially useful in college classrooms across disciplines that could focus on college-health related projects. Discussion of elements of the guidelines that did or did not function as expected would be as useful to future researchers as the actual campaigns and interventions created, perhaps leading to a real shift from the dominant to the participatory paradigm. Future researchers might also assess the success of this design using alternative methods, for example, pre- and post-test surveys of community researchers, or analyses of campaign products produced (e.g., content coding).

Conclusion
Many scholars, including those in development communication, have called for paradigms that include community-based participatory approaches [3, 4, 13, 15, 16, 17, 19]. The dominant paradigm of development and modernization is not sufficient for all situations or all places, all of the time [1, 2, 3, 4, 5], and researchers suppose that is due to the lack of inclusion of the target population. Those development failures should be given great consideration by future researchers, particularly those interested in the pursuit of superior applications and health initiatives offering improved outcomes for the people the initiatives are meant to help. It is the responsibility of today’s communication professionals to engage paradigms and methods that involve the people of the culture targeted for development in designing better futures for themselves.

With that in mind this chapter argues that the CBPR approach as part of an interdisciplinary framework is viable in future health communication projects given the greater presence of stakeholder investment, as well as its collective, rather than individualistic foundation. CBPR can be used to advance the goals of empowerment education as well as development that seek to empower individuals to lead better lives, in ways that those individuals have defined as better. We hope our critical ethnography investigating participation, community, pedagogy, and the application of models in health and development campaigns initiated in a health communication classroom on a Midwest campus has enhanced understanding of how active stakeholder involvement might lead to positive and directed social change.

Overall, our analysis revealed evidence of how an actual participatory process that unfolded in a university classroom mirrored interdisciplinary guidelines presented in this chapter. We also found evidence of divergence from those guidelines and offered an updated set of guidelines modified to reflect our analyses. Thus, although the process and results of our CBPR project have not been as straightforward as a project conducted within the dominant paradigm, community involvement in our CBPR campaign has been ongoing and expanding, suggesting positive outcomes for future projects utilizing an interdisciplinary CBPR approach.

*authors contributed equally to this work
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34. OneDrive [Internet]. [cited 2015 Apr 12]. Available from https://onedrive.live.com/?id=89969949EEF43CE3%211107&cid=89969949eef43ce3&authkey=%21AtAf_QJ1o6dDAw&v=3
### Table 1. Community-based participatory research guidelines: An interdisciplinary approach

<table>
<thead>
<tr>
<th>Stages</th>
<th>Recommendations</th>
</tr>
</thead>
</table>
| Stage 1: Research and Assessment<sup>a</sup> | • Dialogic Mode for identifying, analyzing and refining the understanding of audiences/stakeholders, risks, opportunities, needs, solutions, media channels, and monitoring and evaluation indicators. Objectives are assessed here and assessment and definition of objectives continues into Stage 2<sup>b</sup>  
• Try answering the questions: What do we “SEE” here? What is really “Happening”? How does the story relate to “OUR” lives? “WHY” have they become/done this (as related to specific behavior)<sup>b</sup>  
• Identify research questions; assess community strengths, assets and challenges; define priorities<sup>c</sup> |
| Stage 2: Strategy and Design<sup>a</sup> | • Monologic and Dialogic Mode during which communication approaches, messages, and learning systems are selected and designed. The work plan is developed here and its development continues into Stage 3<sup>a</sup>  
• Develop research and data collection, and methodologies; collect/analyze data and interpret findings<sup>c</sup> |
| Stage 3: Implementation<sup>a</sup> | • Monologic and Dialogic Mode during which pretests are conducted, media is produced, training activities are undertaken, and messages are disseminated<sup>d</sup>  
• Try answering the questions: How can all be “EMPOWERED?” What can we “DO” about it?<sup>b</sup>  
• Disseminate findings, apply findings to address action<sup>c</sup> |
| Stage 4: Monitoring and Evaluation<sup>a</sup> | • Monologic and Dialogic Mode during which the communication program and performance and impact of the campaign/intervention are evaluated<sup>a</sup> |

NOTE: Monitoring and evaluation are continual throughout the progression of stages but most evident in Stages 1 and 4.


**Table 2.** Revised CBPR interdisciplinary guidelines: Updated following a critical ethnography.

<table>
<thead>
<tr>
<th>Stages</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage 1:</strong></td>
<td></td>
</tr>
<tr>
<td>Research and Assessment&lt;sup&gt;a&lt;/sup&gt;</td>
<td>- Dialogic Mode for identifying, analyzing and refining the understanding of audiences/stakeholders, risks, opportunities, needs, solutions, and media channels. Objectives are assessed here and assessment and definition of objectives continues into Stage 2&lt;sup&gt;a&lt;/sup&gt;</td>
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<tr>
<td></td>
<td>- Monologic Mode may also be present as researcher/teacher facilitates the group/class with assignment guidelines*</td>
</tr>
<tr>
<td></td>
<td>- Try answering the questions: What do we “SEE” here? What is really “Happening”? How does the story relate to “OUR” lives? “WHY” have they become/done this (as related to specific behavior)&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Stage 2:</strong></td>
<td></td>
</tr>
<tr>
<td>Strategy and Design&lt;sup&gt;a&lt;/sup&gt;</td>
<td>- Monologic and Dialogic Mode during which communication approaches and messages are selected and designed. The work plan is developed here and its development continues into Stage 3&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>- Identify research questions; assess community strengths, assets and challenges; define priorities&lt;sup&gt;c&lt;/sup&gt;*</td>
</tr>
<tr>
<td></td>
<td>- Develop monitoring and evaluation indicators&lt;sup&gt;a&lt;/sup&gt;*</td>
</tr>
<tr>
<td></td>
<td>- Analyzing and refining the understanding of audiences/stakeholders continues&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>- Develop research and data collection, and methodologies; collect/analyze data and interpret findings&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>- Pretests are conducted&lt;sup&gt;c&lt;/sup&gt;*</td>
</tr>
<tr>
<td><strong>Stage 3:</strong></td>
<td></td>
</tr>
<tr>
<td>Implementation&lt;sup&gt;a&lt;/sup&gt;</td>
<td>- Monologic and Dialogic Mode during which media is produced, training activities are undertaken, and messages are disseminated&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>- Evaluation and updating of messages continues as analyzing and refining the understanding of audiences/stakeholders also continues&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>- Try answering the questions: How can all be “EMPOWERED”? What can we “DO” about it?&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>- Disseminate findings, apply findings to address action&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Stage 4:</strong></td>
<td></td>
</tr>
<tr>
<td>Monitoring and Evaluation&lt;sup&gt;a&lt;/sup&gt;</td>
<td>- Monologic and Dialogic Mode during which the communication program and performance and impact of the campaign/intervention are evaluated&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>- Select/design learning systems&lt;sup&gt;a&lt;/sup&gt;*</td>
</tr>
<tr>
<td></td>
<td>- Continue interpreting findings&lt;sup&gt;c&lt;/sup&gt;*</td>
</tr>
</tbody>
</table>

NOTE: Monitoring and evaluation are continual throughout the progression of stages but most evident in Stages 1 and 4.
* Updated from guidelines presented by Authors in Table 1 following a one semester critical ethnography.


**Table 3.** Survey Questions developed via CBPR

<table>
<thead>
<tr>
<th>Questions developed in group for class discussion</th>
<th>1. How would you define unwanted sexual advances?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Have you ever experienced an unwanted sexual advance?</td>
</tr>
<tr>
<td></td>
<td>3. Have you experienced many instances of unwanted sexual advances?</td>
</tr>
<tr>
<td></td>
<td>a) If yes, how would you describe the person making the unwanted sexual advancement?</td>
</tr>
<tr>
<td></td>
<td>5. Have you ever made an unwanted sexual advancement toward another person (knowingly or unknowingly)?</td>
</tr>
<tr>
<td></td>
<td>a) If yes, please describe that situation.</td>
</tr>
<tr>
<td></td>
<td>6. Do you perceive a difference between men and women when it comes to unwanted sexual advances? Please explain.</td>
</tr>
<tr>
<td></td>
<td>7. Do you think unwanted sexual advances are a problem on BGSU’s campus?</td>
</tr>
<tr>
<td>Questions refined by class discussion and included on campus survey</td>
<td>1. How would you define unwanted sexual advances?</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td>2. Do you think unwanted sexual advances are a problem on your college campus? If yes, how much of a problem?</td>
</tr>
<tr>
<td></td>
<td>Yes  No</td>
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<tr>
<td></td>
<td>If yes, then how much of a problem?</td>
</tr>
<tr>
<td></td>
<td>3. On a scale from zero to ten with 0 being &quot;not at all&quot; and 10 being &quot;very big problem&quot;, how much of a problem are unwanted sexual advances on your college campus?</td>
</tr>
<tr>
<td></td>
<td>Not at all 1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td></td>
<td>Very big problem</td>
</tr>
<tr>
<td></td>
<td>4. Have you ever experienced an unwanted sexual advance?</td>
</tr>
<tr>
<td></td>
<td>Yes  No</td>
</tr>
<tr>
<td></td>
<td>5. Have you experienced many instances of unwanted sexual advances?</td>
</tr>
<tr>
<td></td>
<td>Yes  No</td>
</tr>
<tr>
<td></td>
<td>How many?</td>
</tr>
<tr>
<td></td>
<td>6. How would you define &quot;consent&quot; in the context of sexual advances?</td>
</tr>
</tbody>
</table>