The Intersection of CBPR, Health Disparities, and Child and Adolescent Mental Health

For more than a decade, communities and their academic partners have used community-based participatory action research (CBPR) to build knowledge and support social justice. CBPR has been referred to as a transformative approach to both qualitative and quantitative research that emphasizes co-learning (through which community and academic partners exchange knowledge and expertise), capacity building (in which partners commit to training community members in research processes and other skills), mutual benefit (through which knowledge produced by the research process benefits all partners), and a long-term commitment to eliminating health disparities. By exposing and addressing systemic factors influencing health behavior and tackling issues of concern to stakeholders in the community, CBPR is well suited for bridging gaps in health disparities research and addressing questions of interest to readers of the *Journal of Child and Adolescent Psychiatric Nursing*.

CBPR's Historical Context

Drawing on constructivist and critical theory, CBPR is rooted in Lewin's work on cycles of action, reflection, and problem solving (Leung, Yen, & Minkler, 2004; Lewin, 1948; Wallerstein & Duran, 2003). Lewin's work—in the action research tradition—recognized the importance of community action in solving research problems and addressing research questions. A second tradition—the participatory research tradition—emerged during the 1970s as academics from Africa, Asia, and Latin America reexamined their social obligations in addressing inequity. Participatory research addresses criticisms of the positivist research paradigm, which relies on trained researchers striving toward what they, the researchers, perceive as unbiased processes of inquiry to reveal a single objective reality. This reality was touted as representative of the experience of those being researched. The participatory framework, meanwhile, is grounded in avoiding prioritizing researcher expertness and objectivity over subjective and experiential knowledge. This relatively new framework endorses the Freirian view that reality is defined by the perceptions of the people experiencing it (Freire, 1982; Wallerstein & Sanchez-Merki, 1994).

Since the 1970s, academics have used principles of community organization—focused on coordinating community resources from an outsider's perspective—and community building—which advocates action by community members themselves—in efforts to democratize portrayals of social reality. The incorporation of community organizing and building principles has introduced questions about the role of power and community empowerment in the relationship between researchers and community members, and the affect of that relationship on community members and their health behavior practices. Meanwhile, our understanding of power and community empowerment have also been transformed as research on inequities in health status associated with poverty, racism, and other social determinants grows, matures, and is better understood (Wallerstein, 1999).

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Applying CBPR to Child and Adolescent Mental Health Disparities Research

"Health disparities" describe processes through which inequities in environment, healthcare access, use and quality of services, and health status produce different health outcomes across various groups (Carter-Porkas & Baquet 2002). These inequities produce especially troubling mental health disparities among children and youth who must rely on the adults in their lives to meet even basic needs. Because adults typically mediate child and youth access to health care, the use of a CBPR framework in this context presents particular challenges. These challenges both help to explain the dearth of literature on CBPR among children and youth coping with behavioral and psychiatric issues and introduce an important arena for community, family, and individual engagement in research.

Child and adolescent psychiatric nurses are uniquely positioned to understand how children and youth experience their mental disorders and the adults and peers influencing their lives. However, CBPR asks us to pursue such research while eschewing "top-down" models of communicating with children and youth, and creating space for this disenfranchised population to scrutinize differential health outcomes (Wallerstein & Duran, 2006). Guided by principles of co-learning, capacity building, mutual benefit, and long-term commitment, we must engage children and youth, while avoiding the urge to brandish privileges and powers associated with adulthood. This means establishing longer relationships with youth research partners, eliciting their concerns (problem identification), understanding their preferences for working with us to better understand these

concerns (design, teach research process, determine research roles), including them in all aspects of the research process (data collection, analysis, evaluation, and dissemination), and respecting the validity of data produced by the process. Our view of validity departs from the strictly positivist paradigm, emphasizing, instead, the value of group-generated and culturally specific data that are trustworthy, credible, and well founded in its explanations of phenomenon.

As funding organizations prioritize areas for research among historically marginalized groups, academic researchers will be challenged to reconcile this perspective with conventional research criteria for reliability and validity. Meanwhile, community stakeholders will be called upon to assume more robust leadership roles in the research process even while protecting their interests. In collaborations involving adults and children as co-learners and collaborators, these research orientations may introduce a complex new research dynamic that, while challenging in its novelty, offers myriad rewards.

Mikhaila Richards, MS
Research Assistant
Georgetown University
O'Neill Institute for National and Global Health Law

Edilma L. Yearwood, PhD, PMHCNS, BC, FAAN
Associate Professor
Georgetown University
School of Nursing & Health Studies

Author contact: mr78@georgetown.edu, with a copy to the Editor: poster@uta.edu

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