

Editor's Introduction

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Writing about Dostoevsky's work, M.M. Bakhtin wrote that he heard *voices* in everything and *dialogic relations among them*.¹ By this Bakhtin meant that the characters in Dostoevsky's novels took over the author's story as unique persons, each of them unique voices engaged in conversations with one another. Along these lines, I see the authors in this issue taking part in a meta-dialogue that is, endeavoring to build a dialogic understanding of communication. In examining healthcare voices speaking for what is and what could be, the six articles in this first issue of 2018 tell us about providers, patients, and the social and cultural contexts which give meaning to them as both distinct speakers and interlocutors. From the opening article, which features the voice of Louise Phillips, author of the insightful critique of action research *The Promise of Dialogue*,² we are presented with a notion of dialogue not as agreement or harmony (as it is often misconstrued) but as a fascinating tension for analysis.

In *De-romanticising dialogue in collaborative health care research: a critical, reflexive approach to tensions in an action research project's initial phase* dialogic researchers and practitioners Phillips, Ravn, Scheffmann-Petersen, Helle and Merete Nordentoft take on the romantic notion of dialogue as symmetrical, power-free and inclusionary communication, a sort of unicorn to be captured in ideal research practices. The authors develop their critique reflexively, from the inside out, by paying attention to the ways in which, in their own narrative of collaboration, the discourse is made up of

productive asymmetries, dilemmas and tensions, and how these actually allow – rather than impede – communication. To claim that something is dialogic in the romanticized sense, without understanding that dialogue is fraught with tensions and possibilities, is, as the authors note, a claim to authorize the researchers' voice over those of others. The articles that follow touch on Phillips *et al.*'s observations by rejoining dialogues in different healthcare situations, and underscoring the role of different voices in conversation with each other; in each of these insightful qualitative research studies, we find participants engaged in discussions about difficult matters and that, therefore, matter a great deal for communication.

In *Waiting for the doctor to ask: influencers of lesbian, gay, and bisexual identity disclosure to healthcare providers*, Hudak and Carmack analysis of interviews with LGBT patients addresses an important gap health communication research. The authors examine patients' understanding of disclosure about sexual orientation and how they go about deciding how to navigate asymmetries of knowledge and authority. As a communication scholar interested in institutional asymmetries and authority, I find it interesting how disclosure in healthcare tends to be theorized as one-way communication (for providers are not presumed to disclose) and therefore materialized as an a priori barrier in research questions. Hudak and Carmack's study argue that heteronormativity is also an a priori assumption, and that patients' decisions to tell providers otherwise is an important move in dispelling it, and creating the tension *necessary* for dialogue to occur. The authors' analysis suggests that (dialogue about) disclosure is contingent on the ways in which patients imagine the possibilities of dialogue with practitioners. In turn, this tells us about the fragility of identity and the need to protect it from scrutiny, and the dilemmas between what could and should be known. Because the way patients imagine practitioners' responses has everything to do with their own communication disclosure is not a one way street at all, but, as the authors contend, everyone's effort and a multi-voiced exchange.

The research studies by Carmack and Serafin and Hook, Plump and Geist-Martin continue in this vein. Reading them, I am reminded of what Blommaert calls superdiversity³ or the speaking from diverse if not conflicting positions, with each voice embodying multiple

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identities. In *College students' communication about complementary and alternative medicine practices*, for instance, we find out that college students who have chosen complementary and alternative medicine (CAM) over traditional approaches will not tell others about their choice unless asked. As a person with severe fibromyalgia surrounded by so many with debilitating autoimmune conditions, environmental allergies and food intolerances, this article truly resonated with me. As Carmack and Serafin's interviewees discuss, Western medicine seems to have neither interest, understanding, nor treatment for any of the complexities of chronic suffering; instead, patients like me have found relief with modalities such as acupuncture, massage modalities, meditation, aromatherapy, or reiki. Yet we who are suffering may not initiate conversations our well-reasoned decisions, for fear of being judged or generally stigmatized by others – and especially so by healthcare practitioners. Because these conversations need to happen if patients want others to take CAM seriously, and especially to educate the medical community about the benefits of CAM, I agree with the authors' recommendation that we become proactive in instigating them.

As if taking the next turn in a conversation between patients, providers, the researchers and multiple other addressees, the study by Hook, Plump and Geist-Martin takes the perspective of integrative medicine (IM) physicians. In *Advocating for integrative medicine: providers' stories of resonance, negotiation, and community* the authors point out that IM – a blend of complementary, alternative and biomedical approaches – is an ancient and well-established tradition, tracing back to the work of Aristotle. Notwithstanding, patients who benefit from IM often will not volunteer the reasons for their choice (and this we know from Carmack and Serafin, too!), leaving providers to advocate for what they do. As the narratives of IM providers tell us, their ability to promote what they do depends on negotiating their convictions in a broader political climate, and biomedically oriented colleagues who can be less receptive to IM for a variety of reasons, including protecting their own turf. For IM providers to advocate for their work thus requires that other voices rejoin their own – those of donors and patients most prominently. As Hook *et al.* point out, doing qualitative research with interviews and narratives, which means making the study itself a site for the materialization of dialogue, is itself an opportunity for advocacy, for it allows providers and patients alike to speak.

And this means that new ways of materialization, or of bringing forth experience by way of dialogue do emerge. *Our family portrait: the church as a model of social support* offers an example of how this works. In her study Liza Ngenye examines how the metaphor of church as family works as a way for members to build a relational practice as well as to make sense of their fit within the

church. In a sense, members are in constant dialogue with each other and the church itself as a figure of what Ngenye interprets as social support; it is this dialogue which members have qua family members which, in turn, justifies having the pastor as father figure, for example, in charge of the spiritual health of his family/flock. So, the way we position ourselves in communication allows for certain forms of communication to actualize, to actually become the church.

The final article in this issue, *Bad girl and unmet family planning needs among Sub-Saharan African adolescents: the role of sexual and reproductive health stigma* by Stidham Hall, Manu, Morhe, Dalton, Sneha Challa, Loll, Dozier, Zochowski, Boakye and Harris builds on Goffman's notion on stigma as discredited and tainted identity to examine how it affects the possible dialogues of young women in Ghana. That of *bad girls* – from tarnished, spoiled and morally failed families – is the identity category that community elders assign to adolescent girls who seek sexual and reproductive healthcare. The only way for the girls to renegotiate their voice (or claim one at all) is to marry or become more socially accomplished, therefore transcending their doomed future. Therefore, their need for a conversation about sex and family planning cannot happen on the adolescents' terms. Through their analysis, the authors allow for a multiple appreciation of dialogue as a productive way of understanding of communication, first, by allowing us to realize the multiplicity of realities available according to the conversations (or silences) that we are able to enact; second, by connecting these realities to material consequences, reproductive health, in this case, and in case of the other studies in this issue advocacy, disclosure, ways of doing research and ways of being supported in a church setting and thirdly, by taking an ontological approach to dialogue that allows us to acknowledge what we have created in our research practices.

I hope this issue raises questions, brings about dynamic and productive conversational tensions, and initiates disclosures.

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