Community-based Participatory Research (CBPR): Towards Equitable Involvement of Community in Psychology Research

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Abstract

Community-based participatory research (CBPR) answers the call for more patient-centered, community-driven research approaches to address growing health disparities. CBPR is a collaborative research approach that equitably involves community members, researchers, and other stakeholders in the research process and recognizes the unique strengths that each bring. The aim of CBPR is to combine knowledge and action to create positive and lasting social change. With its origins in psychology, sociology and critical pedagogy, CBPR has become a common research approach in the fields of public health, medicine and nursing. Although it is well-aligned with psychology's ethical principles and research aims, it has not been widely implemented in psychology research. The present article introduces CBPR to a general psychology audience while taking into account the unique aims of and challenges in conducting psychology research. In this article, we define CBPR principles, differentiate it from a more traditional psychology research approach, retrace its historical roots, provide concrete steps for its implementation, discuss its potential benefits, and explore practical and ethical challenges for its integration into psychology research. Finally, we provide a case study of CBPR in psychology to illustrate its key constructs and implementation. In sum, CBPR is a relevant, important and promising research framework that may guide the implementation of more effective, culturally appropriate, socially just, and sustainable community-based psychology research.

Keywords

community-based participatory research; participatory action research; CBPR; patient-centered outcomes research; community-engaged research; community-academic partnerships

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Community-based participatory research (CBPR) is an innovative research paradigm that combines knowledge and action to improve community health and reduce health disparities (Wallerstein, Duran, Oetzel, & Minkler, 2017). CBPR provides a framework to equitably involve community members, researchers and other stakeholders in the research process, recognizing and maximizing the importance of their diverse contributions (Wallerstein & Duran, 2006). Its aim is to create positive, transformative and sustainable change together with, for and in communities.

In the field of psychology, CBPR can enhance research efforts in addressing mental health disparities in access, effectiveness, uptake and reach of treatments and programming for marginalized groups (e.g., among ethnic and racial minorities; Belone et al., 2016). CBPR is well-positioned to do so because it provides an inclusive and flexible research framework that fosters cultural humility, colearning and trust and thereby allows for more patient-

centered, transformative and pragmatic approaches to the research process. Despite its promise, CBPR has been underutilized in mainstream psychology research and practice (Bogart & Uyeda, 2009).[1] A recent, but as yet unpublished systematic review conducted by one of the authors (PRE) revealed that CBPR studies comprised 0.1% of publications in peer-reviewed psychology journals.

In this article, we introduce CBPR to a general audience of psychologists and demonstrate its potential for application in psychology research. Specifically, we a) review some historical highlights of CBPR, b) define its key principles, c) differentiate it from traditional, researcher-centered practice, d) provide steps to integrating CBPR into psychology research, e) discuss its potential benefits, and f) introduce important ethical and practical considerations. Finally, we present a case study of CBPR in a psychology research context to show these constructs and processes in practice.

Historical Highlights of CBPR

CBPR lies at the nexus of various academic and activist movements; however, its roots may be found in the 'northern' and 'southern' traditions (Wallerstein et al., 2017).

Northern tradition

Kurt Lewin, a key figure in social and organizational psychology, rejected the positivist belief that researchers could 'objectively' study an individual in the laboratory. Instead, he conducted applied research, valuing the study of human behavior in real-world environments from multiple perspectives (Lewin, 1939). In the 1940s, Lewin first coined the term 'action research,' which refers to research that solves a pressing problem using community effort, and described an iterative process of 'comparative research of the conditions and effects of various forms of social action and research leading to social action' (Adelman, 1993; Lewin, 1946). This work inspired many social scientists to engage in research that creates positive and lasting social change (Snyder, 2009; Wallerstein et al., 2017).

Southern tradition

The Southern tradition encompasses CBPR approaches from South America, Africa and Asia (B. Hall, Tandon, & Tremblay, 2015). This tradition arose from the challenges faced in developing countries (e.g., colonizing role of research, oppression from despotic regimes) and proposed solutions (e.g., liberation pedagogy, post-Marxist approaches; Duran & Duran, 1995; Freire, 1970).

In the late 1970s, Colombian sociologist, Orlando Fals Borda and colleagues organized the first participatory action research conference (B. L. Hall, 2008). At this conference, there were calls for community action and involvement to be incorporated into more traditional research plans and thereby avoid the monopoly on learning and knowledge that often results from top-down researcher-community relationships. This type of research was dubbed participatory research and, eventually, participatory action research and CBPR.

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[1]It should be noted that a few fields of psychology have embraced and contributed to the development of CBPR, especially community and social psychology.

Defining Principles of CBPR

The principles of CBPR (Israel, Schulz, & Parker, 2012; Wallerstein et al., 2017), which we summarize below in a psychology research context, are neither absolute nor comprehensive. CBPR is a flexible approach that must be adapted for diverse community partnerships. The principles do, however, convey the spirit in which CBPR must be practiced and they expose and contrast with fundamental and often implicit assumptions of traditional psychology research (see Table 1 for a comparison of research approaches).

Community is the key unit of identity in CBPR

In most branches of psychology, participants are individuals, and individuals are the primary unit of identity. CBPR practitioners acknowledge that individuals belong to larger, socially constructed identities that shape strengths, challenges and disparities. Thus, individuals are viewed as embedded within their communities, which are characterized by connection and identification with other individuals, common symbol systems, shared values and norms, mutual influence, common interests, and joint commitment to meeting shared needs (Wallerstein et al., 2017). Communities may be defined by geographical boundaries or may be dispersed across geographical place but have a common identity or shared fate (Wallerstein et al., 2017). Communities must be defined, engaged and involved in the research process to maximize the psychological and physical health of their constituents. A CBPR framework has often been applied in working with marginalized communities that experience health disparities and inequities; however, CBPR principles may be applied in work with various types of communities, including those not traditionally considered marginalized (e.g., police officers, health care workers, business management).

CBPR addresses issues of race, ethnicity, sexism and social class and embraces cultural humility

CBPR practitioners are committed to identifying and addressing social determinants of poverty, discrimination, and racism (Minkler, Garcia, Rubin, & Wallerstein, 2012). In doing so, CBPR practitioners cultivate cultural humility, which has been defined as having an accurate view of one's own identity; not assuming one's own identities, values and perspectives are superior to others'; and being open to and interested in the identities, values and perspectives of others (Hook, Davis, Owen, Worthington Jr., & Utsey, 2013). They recognize their own intersecting social identities (e.g., race, ethnicity, gender, education, socioeconomic status), critically examine their impact on their own and the community's engagement in research, and address resulting power imbalances (Tervalon & Murray-Garcia, 1998). It also requires that researchers recognize they do not have a monopoly on knowledge. The Western scientific literature base is one way of assessing what could be helpful for a community to consider in research design and intervention development; however, members of the community have other 'ways of knowing' that could complement the scientific evidence base, and these perspectives must be integrated into the research process.

CBPR is guided by an ecological, multideterminant perspective

CBPR practitioners consider research questions from an ecological perspective that acknowledges that health status is not solely individually determined, but is shaped by larger familial, community, societal and even geopolitical forces (Bronfenbrenner, 1979). For these reasons, it is important to have multidisciplinary (e.g., psychologists, physicians, social workers, nurses, case managers, public health experts, community members, other community stakeholders) and identity diverse (e.g., age, gender, race, ethnicity, sexual orientation, class, life experience) teams to provide a differentiated and comprehensive set of perspectives to inform the research process.

CBPR aims to build equitable research partnerships

CBPR emphasizes collaborative, equitable partnerships among researchers, stakeholders and community members throughout all phases of research (Minkler et al, 2008a; 2008b). Researchers acknowledge power differentials and ameliorate these through building trust, mutual respect, and community empowerment. Communities are involved in decision-making throughout the research process, from developing research questions to disseminating research findings.

CBPR researchers acknowledge and promote community strengths

Foundational to a CBPR approach is the acknowledgment of communities' strengths, including local and institutional knowledge (e.g., gatekeepers, historical and larger community perspectives, communication styles) and skills (e.g., community engagement, relationship building, data collection and interpretation). When they appreciate and support community members' strengths and skills, researchers recognize community members as valuable and valued contributors to the research process. This contribution promotes colearning between researchers and community members to increase collective knowledge and skills. It also builds community members' self-efficacy and investment in research and better facilitates research implementation. Ultimately, researchers and community members co-own the research process and resulting products.

CBPR practitioners support communities' existing strengths through capacity building. What capacity building looks like varies from project to project, but generally, it refers to the assessment of the strengths and needs of individuals and their communities and the provision of assistance in further developing community members', institutions' and organizations' skills, resources, and competencies (CTSA Community Engagement Committee Task Force, 2011).

The CBPR process is cyclical and iterative

Initially, researchers work with the community to define the research question, which may need to be more clearly circumscribed or redefined over the course of the research process. Further, as ongoing research reveals additional information about the community's needs, strengths and interim outcomes, research methods and interventions are recalibrated as necessary. Given this cyclical and iterative progression, research methods, endpoints and deliverables cannot be entirely fixed at the start of the research process.

CBPR strives to create relevant, sustainable and positive change for communities

CBPR practitioners aim to contribute to generalizable, scientific knowledge while also ensuring that community partners experience lasting benefits from research collaborations (Israel et al., 2006). Such benefits can include individual and community interventions that become embedded in the existing community or larger policy change (Khodyakov et al., 2011). These benefits should endure beyond the timeframe of any specific research project and thus should be able to be maintained by the community after the research is completed.

Steps to Implementing CBPR in Psychology

We have conducted community-based research projects within various, diverse communities (e.g., youths with disabilities, police officers, LGBTQ communities, homeless populations, substance users, immigrant Latinx, urban and reservation-dwelling American Indians and Alaska Natives, African American and African-born populations). Despite the unique features of these populations and research programs, there are some universal steps we recommend in conducting CBPR in psychology.

Practicing reflexivity

People live, work and communicate from various perspectives and positions that are shaped by intersecting aspects of social identity (e.g., race, ethnicity, gender, sexual orientation, socioeconomic status, education, religion) and that impact people's experience of power, oppression and privilege. Prior to and throughout the CBPR process, psychology researchers must engage in reflexivity, which means becoming aware of, critically examining and owning one's privilege, power and patterns of intentional and unintentional classism and racism (Muhammad, Wallerstein, Sussman, Avila, & Belone, 2015). Understanding and accurately representing intersecting positionalities in relation to community partners is essential to ensuring researchers are authentically engaging in power-sharing, committing to colearning, and creating lasting positive impact (Muhammad et al., 2015).

Building and maintaining relationships with the community

CBPR practitioners prioritize the development and maintenance of strong, positive relationships with partnering communities. It is important to have an existing connection or to work diligently to develop one over time. This connection may have grown organically because the researcher identifies as a community member, has worked with the community through prior research or service collaborations, or has been approached by the community for help with a specific topic. To develop new CBPR partnerships, researchers may contact community stakeholders to assess their interest in collaboration. Most important, the connection must be of interest to the community.

Trust is an essential component of effective CBPR partnerships (Lucero & Wallerstein, 2013; J. E. Lucero et al., 2016). Building trust is less about formal meetings and procedures and more about consistently "showing up" for the community. "Showing up" does not just entail attendance at planned project meetings but support of community activities. For example, in working with American Indian and Alaska Native communities, one might attend social (e.g., Pow Wows, community dinners, talking circles) or health-related

activities (e.g., walkathons and fundraisers supporting Native health initiatives). In working with homeless communities, one might serve meals at drop-in centers, participate in community-based agency fundraisers, or help organize volunteer activities at shelters. The key to building strong relationships in CBPR is showing authentic and consistent support for communities on their terms.

Engaging communities in the research process

Once a connection is established, researchers a) meet with members of the community, b) assess together with community members who should be at the table to ensure adequate representation, and c) establish a community advisory board or other participatory structure (Newman et al., 2011). In community advisory board meetings, it can be helpful to engage in ice-breaking and team-building exercises to build trust among the partners. Procedures can be tailored to a community's needs to optimally facilitate communication and decision-making and to create a more equitable distribution of power (e.g., break-out groups, anonymous voting, group discussion, one-on-one meetings). Ideally, meetings are held in the community or in a mutually accessible and agreed-upon place.

Recent studies have elucidated evidence-based factors for successful community partnerships and research involvement, including adherence to CBPR principles and strategies (Cyril, Smith, Possamai-Inesedy, & Andre, 2015), a commitment to building trust among partners (Jagosh et al., 2015), and formal structures to ensure equitable community involvement (e.g., written agreements; Oetzel, Villegas, et al., 2015). For populations that are more severely impacted by psychological disorders, equitable involvement might entail making accommodations similar to those one might make for those with mobility impairments. Examples from our own research experience include not turning away alcohol dependent individuals who need to drink to stave off withdrawal prior to two-hour community advisory board meetings and using an accessible reading level for materials and reading them aloud in meetings to accommodate those with learning disabilities or cognitive impairments. CBPR practitioners must take into account all partners' strengths and challenges and work together to maximize the former and build in support for the latter.

Recent research has indicated that fundamental aspects of the community-researcher partnership can and should be measured and assessed over time, including relational dynamics in the partnership (e.g., leadership, influence, participatory decision-making), systems and capacity changes (e.g., new financial support streams for communities, increased ability to affect policy), and community health outcomes (Oetzel, Zhou, et al., 2015).

Cocreating the research question

The research question must be grounded in the interests and needs of the community. Ideally, the community approaches the researcher with a need, research question or desired direction. Research questions may come from researchers or communities when building on prior, collaborative projects. Researchers may also approach the community to gauge interest in codeveloping solutions to known community problems. This last pathway may be particularly helpful with marginalized communities that are not necessarily empowered to

connect with researchers of their own accord. Foremost, the community must consider the research question to be relevant, important and actionable, and the researcher must be willing to learn about the research questions and context from the community.

Mutually deciding on the division of labor

Once the research question is established, the strengths and needs of researchers and community members must be discussed to establish the division of labor. There must be an equitable—not necessarily equal—partnership in research implementation. Some communities have the interest and resources (e.g., time, training) to implement certain aspects of the research project (e.g., participant interviews, qualitative coding, writing). Other communities may ask researchers to take on tasks that would otherwise be burdensome (e.g., accessing research grant funding to support the work). These decisions should be made as a team with a focus on equity, capacity building and sustainability. Generally, greater community involvement leads to more productive partnerships, better research programs, and stronger implementation (Minkler et al., 2009).

Disseminating the research together with the community

Traditionally, research findings are shared in academic journals and at scientific conferences (see Table 1). In CBPR, researchers share findings with communities as well as with members of the scientific community to bridge the research-practice gap (Chen, Diaz, Lucas, & Rosenthal, 2010). Community members can suggest effective means of disseminating the study information, and a more comprehensive and community-driven dissemination plan ensures that the larger community is aware of the research and can maximally benefit from program implementation. It also offers an opportunity for community members to be involved in dissemination efforts, which can better place findings in context as well as build community capacity. Researchers should build in funds for community members to attend scientific and community-oriented conferences and meetings and should collaborate with community partners as coauthors.

Advantages of Conducting CBPR in Psychology

As psychologists and researchers, we have experienced firsthand the many advantages of using a CBPR framework within psychology research. In this section, we share some of these advantages, many of which are supported by current mandates in the field and by recent empirical evaluations of CBPR as a research framework.

CBPR expands upon current mandates of patient-centered research and practice

Various government agencies have stressed the importance of research methods that better address the complex social and environmental factors involved in health disparities and increase the equitable involvement of communities in health-related research (Israel, Eng, Schulz, & Parker, 2012). Accordingly, funding agencies, including the National Institute on Minority Health and Disparities (NIMHD), Agency for Healthcare Research and Quality (AHRQ), Substance Abuse and Mental Health Services Administration (SAMHSA), and Patient Centered Outcomes Research Institute (PCORI) have created mechanisms to support these efforts.

Further, the premise of CBPR – to equitably engage communities in the research process and thereby ensure their benefit from research – is consistent with the tenets of patient-centered care, which calls for "care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions" (IOM, 2001). However, CBPR takes this concept to the next level. Specifically, psychologists practicing CBPR avoid pathologizing individuals or placing them in traditional hierarchies (i.e., researchers, academicians, clinicians versus research subjects, clients, patients). Individuals are first viewed as human beings who organize themselves into larger communities.

CBPR can strengthen psychology's ethical framework

By more explicitly and equitably involving communities in the research process, psychology researchers may more faithfully uphold the general principles (American Psychological Association, 2002, 2010). For example, the principle of fidelity and responsibility highlights the importance of being accountable to the "specific communities in which [psychologists] work." CBPR also serves the principle of justice, which recognizes that all people should have "access to and benefit from the contributions of psychology and to equal quality in the processes, procedures and services being conducted by psychologists." CBPR upholds principles of community autonomy, social and community justice, and community beneficence (Mikesell, Bromley, & Khodyakov, 2013) and provides a clear framework for ensuring the right to self-determination and culturally appropriate programs, which are named in the general principle of respect for people's rights and dignity.

CBPR improves the validity of research methods

Recent systematic reviews and meta-analyses have indicated that a CBPR approach may improve studies' internal and external validity. For example, CBPR often entails community involvement in measure development, iterative field testing, and revision of research measures, which has been shown to improve their psychometric properties (Nicolaidis et al., 2015; Viswanathan et al., 2004). In addressing researchers' concerns that community involvement could compromise internal validity (Bogart & Uyeda, 2009), a review of 60 community health studies concluded that CBPR does not (Viswanathan et al., 2004). In fact, by enhancing recruitment and retention efforts, particularly in marginalized and hard-to-reach populations (Jagosh et al., 2012), CBPR may decrease attrition and selection bias and thereby improve internal validity. Further, more rigorous research designs, such as randomized controlled trials have entered the CBPR literature at an exponential rate (Cook, 2008; De Las Nueces, Hacker, DiGirolamo, & Hicks, 2012). Finally, the implementation of research in community settings versus tightly controlled laboratory environments may boost studies' real-world generalizability (De Las Nueces et al., 2012) as well as their rigor, relevance and reach (Balazs & Morello-Frosch, 2013).

CBPR is well-positioned to increase the effectiveness of psychology interventions for individuals and their communities

To date, CBPR has largely been conducted in the public health, medicine, and nursing fields. Interventions generated using a CBPR framework have been effective in improving community health across populations and health outcomes (O'Mara-Eves et al., 2015).

Beyond participant-level, health-related outcomes, CBPR is associated with improved outcomes for community members involved in the research process as well as increased capacity at the community level (Jagosh et al., 2012; Khodyakov et al., 2011). Given its promising findings and its ability to engage hard-to-reach, marginalized populations, CBPR is well-positioned to address health disparities (Tapp, White, Steuerwald, & Dulin, 2013).

Although CBPR is not yet a mainstream practice in psychology research (Bogart & Uyeda, 2009), there has been an uptick in CBPR-related publications addressing mental health issues in the last few years (e.g., Betancourt, Frounfelker, Mishra, Hussein, & Falzarano, 2015; Lu, You, Man, Loh, & Young, 2014; Michalak et al., 2016; Stacciarini, Shattell, Coady, & Wiens, 2011). Randomized controlled trials involving CBPR and psychological interventions are underway (e.g., Chung et al., 2010); however, there is not yet an adequate literature base to draw definitive conclusions about CBPR-generated interventions' overall effectiveness.

CBPR may close the research-practice gap

On average, it takes biomedical interventions 17 years to move from research to practice (Morris, 2011). In contrast to traditional biomedical interventions, however, CBPR-generated interventions are created with, for and in the community they intend to serve. Thus, CBPR is well-positioned to effectively close the research-practice gap. First, it increases the cultural and contextual relevance as well as the appropriateness of interventions and initiatives (Fleischhacker, Roberts, Camplain, Evenson, & Gittelsohn, in press), which may make these approaches more appealing to communities. Further, CBPR improves relationships between researchers and community members, which can facilitate moving cocreated research, interventions and policies into practice (Minkler et al., 2009). Finally, CBPR entails investments in capacity-building to ensure communities are better equipped to integrate and maintain interventions in the field (Viswanathan et al., 2004) and support future community-based research efforts (Souleymanov et al., 2016).

Ethical and Practical Challenges for CBPR in Psychology

Equitable involvement of communities in psychology research engenders new and challenging ethical and practical dilemmas. In the next section, we review common challenges researchers might face—codefining an ethical framework, navigating multiple relationships, protecting privacy and confidentiality, and resolving conflicts of interest—and their solutions. Although these points are reflective of some of the challenges of conducting CBPR more generally (Drahota et al., 2016; Israel et al., 2006; J. Lucero et al., 2016; Mikesell et al., 2013), they are not comprehensive and are instead tailored to the psychology research context.

Codefining an ethical framework

It is assumed that psychology researchers are responsible for interpreting and applying the general ethical principles in their research practice. For optimal interpretation of the principles, consultation with "other professionals and institutions" is encouraged (American Psychological Association, 2002, 2010). There is, however, no reference to consulting with

the community as a whole, nonprofessional community experts, or research participants as individuals. The exclusion of community voices from the research process can negatively impact psychology practice with marginalized populations (e.g., Indigenous people; Garcia, 2014). Given CBPR's commitment to equitable research partnerships and codevelopment of the research process, psychologists cannot be solely responsible for creating an ethical framework; they must share this responsibility and power with their community partners and other stakeholders.

To facilitate the codevelopment of an ethical framework, transparency about professional and institutional roles, responsibilities and values is indispensable. It is important to have frank discussions with community partners about researchers' limitations and boundaries, which are dictated by psychology-specific (e.g., APA general principles and ethical standards) and other regulations (e.g., Declaration of Helsinki, Belmont Report, universities' and research institutions' regulations, oversight from IRBs, federal regulations such as 45 CFR 46).

That said, sometimes researchers need to bring the community's concerns to their own institutions and advocate on behalf of the community. In such cases, one might, for example, schedule in-person meetings with IRB committee members to provide information on CBPR, present research-informed risk-benefit ratios, discuss appropriate safety measures, and invite interested members of the community and providers who serve the community to speak in support of the research moving forward. CBPR practitioners can advocate for policy changes and institutionalized guiding principles in their departments or organizations to better recognize and integrate the ethics of local communities in research (Straits et al., 2012).

Managing multiple role relationships

In CBPR, multiple role relationships may be more frequently encountered and more complex than in traditional research. It is important to be transparent about all the roles one plays in the community, the power stemming from each, and the ways in which one can engage in power-sharing. It is invaluable to seek consultation from colleagues who are psychologists as well as CBPR practitioners and have some degree of distance from these specific relationships. This consultation can offer an additional intersubjective perspective for psychologists to consider and include in their interpretations and decisions regarding their roles and relationships.

Protecting privacy and confidentiality

In the traditional psychology research context, it is accepted practice that researchers reveal neither the identities of research participants nor identifiable characteristics of the community from which participants were recruited so as to protect privacy and confidentiality. It is assumed that research participants will not be actively involved in shaping the research message or disseminating findings.

In CBPR, these assumptions are challenged by the additional ethical imperative to involve communities and community members at all points in the research process. Community members and participants may have an interest in shaping the interpretation of the findings,

coauthoring manuscripts, and copresenting findings at meetings. To honor this interest, it is important to involve communities and individual research participants in discussions and decision-making about balancing privacy and confidentiality with equitable involvement. When community members and participants find it desirable, they should be involved in dissemination of research findings. Prior to their involvement, it is advisable to inform them of the potential risks of using personally identifiable information in research reports and in copresenting findings. Researchers may also offer advice about how they might protect themselves legally and psychologically when they are coauthoring or copresenting findings by providing a risk-benefit ratio assessment from a researcher perspective; informing them about the challenges of working with researchers, clinicians and journalists in shaping their message; and helping them determine in advance what they feel comfortable sharing about their communities and themselves.

Conversely, some communities want more protections of privacy and confidentiality than are typically afforded in the traditional research context. In research involving smaller communities, for example, descriptions of geographic locations may expose specific groups of people or even individuals, violating privacy and confidentiality. This common research practice has had stigmatizing effects and, as a result, dire psychological, social and economic consequences for participating communities (Foulks, 1989). To address this concern, researchers might describe samples and populations using broader geographical descriptions (e.g., a southwest tribe) or avoid providing specific information altogether (e.g., tribal affiliation).

Conflicts of interest

There are some institutional and disciplinary expectations common in academic and research psychology settings that may conflict with community interests. For example, community timelines (e.g., desire for timely action and intervention to respond to a serious community need or problem) may differ from those at research institutions (e.g., plodding federal grant funding timelines, university IRB reviews). There are also competing demands and agendas on the part of communities and researchers. Young researchers in particular may need to balance their investment of time in building and maintaining community relationships with writing grants and peer-reviewed manuscripts to show academic productivity.

When these conflicts occur, researchers must be reflexive and transparent about their own agendas, listen to their community partners, and move forward with shared decision-making that can ensure both community and researcher priorities are met. Partners may choose to resolve differences through various means—consensus decision-making, voting on important issues—or if these cannot be solved together, bringing in mutually respected mediators to help.

Ultimately, communities or researchers may decide not to enter into or to dissolve a partnership if an absolute impasse is reached. However, a thoughtful fusion of contrasting practices and values—an amalgamation of epistemologies—may lead to new knowledge production, innovative practices, and improved outcomes. It is thus recommendable to make an effort for group consensus that prioritizes the community's needs and interests.

Fortunately, the importance of building and maintaining community relationships has, in recent years, been recognized by funding agencies. Mechanisms are now available to support community-researcher engagement (e.g., PCORI's Community Engagement grants) and may enable researchers to stay fully funded and continue to achieve academic milestones (e.g., grants, publications) while engaging in community relationship building and project development. By financially supporting relationship building and pilot work, such mechanisms can reduce the need for iterative changes later in the process that could otherwise disrupt research timelines.

Putting It All Together: A Psychology CBPR Case Study

In this section, we draw on the experiences of a subset of the authors (SEC, SLC, JS, LN, the LEAP Advisory Board) in the context of federally funded, multiphase CBPR program and treatment development projects. This case study is neither prescriptive nor idealized; it is a real-world application of CBPR in psychology research.

Background and setting

The idea for this work originated within a partnership between a community-based agency, the Downtown Emergency Service Center (DESC), and University of Washington researchers (SEC, SLC). The partnership was formed when leadership at DESC approached the researchers to evaluate the effectiveness of their Housing First[2] model. For this specific evaluation, DESC provided housing to a particularly marginalized and vulnerable group of people: 134 of King County, Washington's highest utilizers of publicly funded services (e.g., use of county jail, emergency department, emergency medical services, shelter) who had severe alcohol use disorders and were chronically homeless. Over a five-year period, the DESC-researcher team jointly published primarily quantitative evaluations of the Housing First model and the trajectories of individuals living there. This collaborative work showed its effectiveness in ameliorating alcohol-related harm, improving housing outcomes, and reducing publicly funded service utilization (Clifasefi, Malone, & Collins, 2013; Collins, Malone, & Clifasefi, 2013; Collins, Malone, et al., 2012; Larimer et al., 2009; Mackelprang, Collins, & Clifasefi, 2014). However, most impressive to the researchers was the resilience, strength, positivity, and capacity for change and growth exhibited by the Housing First residents (Collins, Clifasefi, Dana, et al., 2012; Collins et al., 2017), a group who had been homelessness for a mean of 17 years, had attended substance-use treatment a mean of 16 times, were multiply affected by psychiatric, medical and substance use disorders and, together, had generated over $8 million dollars of public service costs in the year before entering housing (Larimer et al., 2009).

Despite the positive research outcomes, residents told the researchers they continued to experience alcohol-related problems and struggled psychologically with the transition into housing (Collins, Clifasefi, Andrasik, et al., 2012; Collins, Clifasefi, Dana, et al., 2012;

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[2]Housing First entails the provision of immediate, permanent, low-barrier, nonabstinence-based supportive housing to chronically homeless people (Malone, Collins, & Clifasefi, 2015; Tsemberis, 2010), or individuals who are multiply affected by medical, psychiatric and substance use disorders and have been homeless for at least one year or four or more times in the past three years (US Housing and Urban Development, 2007).

Collins, Malone, et al., 2012). DESC's late executive director, Mr. William Hobson, acknowledged this point, and in a meeting, turned to the researchers[3] and asked, "Ladies, we know now it's all about Housing First, but what comes second? You two are the [alcohol treatment and research] experts!" The researchers did not know the answer and thus did the only thing that made sense: They asked the experts—the residents—what could help them continue to reduce their alcohol-related harm and improve their quality of life after they moved into the Housing First program.

Building relationships

During the prior evaluations, the community-researcher team built trusting relationships and a strong research portfolio that was driven by the community-based agency's agenda to create an evidence base for Housing First and support their pursuit of program funding. The research question was raised by the executive director of the community-based agency, who was white, well-educated and had no lived experience of homelessness. Thus, the most important relationship-building moving forward was with residents, a racially diverse and socioeconomically disadvantaged community that had been unfairly maligned in the local press and marginalized in the larger community (Jamieson, 2002; Schram, 2004).

Residents have said that researchers were positive, engaging and open. However, this style was necessary but not sufficient to start the relationship-building process. One author, now a community consultant on research projects noted, "I didn't trust you then. You came in, and we had rifles. Ok, not literally. However, everyone was doubtful of what could be accomplished. Our community…we were broken. It doesn't make us bad, just broken." Perhaps it was also important that researchers did not view residents as broken but as survivors who are more perceptive, resilient and stronger than most housed individuals. Ultimately, community members felt that being treated "like human beings" and "with respect" were key to the success of the relationship. The consistency of researchers' involvement in various house activities—both research (e.g., meeting attendance, participation in programming) and nonresearch-related (e.g., support for community meetings, advocacy to management, visits to residents in the hospital)— was also essential to building long-term, trusting and productive relationships.

Researchers also needed to consider a key construct, coined "WIIFM" (pronounced "wiff-em") or "What's in it for me?" by one author. At first, WIIFM was pizza. Researchers brought pizza to the house and started talking to residents about a research grant they and the agency had received to cocreate and evaluate resident-driven programming for the house. Food was viewed as important by residents because "when you are invited to someone's house, you bring food to share." Later, WIIFM involved more sophisticated asks that went

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[3]In practicing reflexivity, it should be noted that both lead researchers in the case study identify as cisgender (i.e., gender identity corresponds to sex assigned at birth), female psychologists who are faculty at the University of Washington, have doctoral-level educations, and upper-middle-class upbringings. SLC identifies as second-generation Iranian American, heterosexual, and has lived experience of managing a chronic health condition. SEC identifies as European American and bisexual and has lived experience of addictive behaviors and treatment. Neither have been homeless or had a severe alcohol use disorder. Given the similarities and differences between themselves and residents in life experience and intersectional identities, both made ongoing efforts to question and be accountable for their reactions to day-to-day experiences in the research, anxiety about research outcomes, and attachment to the research effort. In addition, they sought out consultation from other CBPR practitioners and psychologists to help address and manage potential conflicts of interest as they arose.

beyond the research parameters but were important to residents who wanted to solve problems affecting their community. To this end, there was reserved space in research meetings for nonresearch issues to be discussed so residents' concerns were heard and acted upon. When necessary, researchers served as mediators between management and residents in identifying pathways for problem resolution (e.g., getting doors locked on the first floor, reinstating community meetings between residents and staff, addressing the issue of residents drinking hand sanitizer). This accommodation served to build trust and resolve immediate and instrumental needs so the team could focus on developing the research programming.

Residents, staff and management have acknowledged the importance of having researchers as a "more objective third party" in both research- and housing-related discussions. That trust and reputation was hard won and tested at various points. For example, at one point, researchers began to advocate for more psychological treatment on behalf of a resident who was also a community advisory board member and was experiencing tension with agency staff due to ongoing paranoid ideation, verbal outbursts and eventually physical violence. What was perceived as advocacy by researchers went on to affect the management and researchers' relationship and raised questions about the boundaries between the agency's and researchers' various professional roles as community advisory board members, participants, researchers, clinicians and housing providers. After a series of meetings, it was collectively decided that researchers should refer residents to management and staff for clinical, medical and housing issues that emerge, and researchers reminded residents of the differences in roles between DESC and the University of Washington. A clear understanding of roles and boundaries was key to building trust and maintaining strong relationships among partners.

Creating formalized structures to further the research

Based on residents' requests in individual interviews and informal focus groups, we created two, monthly meetings convened in community spaces within the house. Residents requested researchers facilitate the meetings to ensure what was perceived as greater objectivity among the stakeholders. At the outset of these meetings, researchers provided initial information on the CBPR approach and on the broadly defined research goal: to cocreate with residents, staff and management programming that helped residents reduce substance-related harm and improve quality of life in resident-defined ways. During the first six months of meetings, attendees engaged in group interviews and ice-breakers with one another to begin to "tear down walls" as well as group brainstorming sessions to cocreate an ethical framework (i.e., collaboratively decide on the groups' values, procedures and goals). Community advisory board members agreed on principles to ensure success: "showing up, making a commitment," "coming with an open mind," "having a third party [researchers] facilitate" because it "decentralizes power a little," having group defined boundaries, "sincerity," commitment to creating "peaceful, nonviolent community" and a "safe space" because "you're not going to get an honest reaction without it, and that grounds the project."

The LEAP Advisory Board meets once monthly and includes researchers as well as Housing First residents, staff and DESC management who were appointed or voted on by peers, based on the various groups' desired process. This board is the primary guiding and

governing body for the research. Lunch is provided at board meetings, and resident members are paid a $20 honorarium for attendance at meetings and related activities. The research grants pay for resident board members' travel expenses and per diem when they copresent work on related projects.

Named by residents, the LEAP Researchers' Group is a monthly drop-in meeting that is open to all residents and serves as an information exchange for researchers and residents as well as a governing body within which residents elect community advisory board members, shape the research design, and give feedback about research programming. About 8-12 residents are typically in attendance. Residents are not paid to attend meetings but refreshments that were suggested by residents are provided. Staff and management of the housing project are not invited to these meetings so as to create an open forum where residents can express their ideas for and concerns about the research and its larger context directly to researchers. In these meetings, housing concerns are redirected to nonresearch-related community meetings, which were heavily advocated for by researchers at residents' behest and on their behalf. Because the researchers had been able to reserve the space and provide refreshments, residents often use the time and space after this meeting for community organizing without researchers present.

Resolving disagreements

In the case of disagreements, all parties committed through the group-defined values to try their best to "stay at the table" and "hash it out." Depending on the context, the team used consensus decision-making and agree-upon voting procedures to collaboratively decide on appropriate group processes, programming content and research design. That said, given the traditional power dynamics and hierarchies present in institutions represented among the stakeholders (i.e., supportive housing agencies, research universities), sometimes residents had to "bang on the table" until researchers and management could hear their ideas. Residents, who have the lived experience of chronic homelessness and are multiply affected by psychiatric, substance use and medical disorders, are used to having their voices marginalized and their interests disregarded in favor of institutional control (Collins et al., 2016). Researchers learned that hearing residents' concerns, ideas and suggestions; incorporating those; and advocating on residents' behalf was key to moving towards equitable relationships, resolving disagreements, and research progress. Because the team was successfully able to do this and come to consensus, there were rarely impasses that could not be bridged.[4] It should also be noted that—even when navigating complex research details—residents consistently had more creative, effective and sustainable ideas than any other stakeholders on the team.

Creating research programming

The goal of the research grant was to develop and evaluate programming that could reduce alcohol-related harm and improve quality of life for residents in a Housing First program.

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[4]In the past decade of research, there was one resident who reported extreme dissatisfaction with the research process. He was eventually asked to leave the Housing First program due to a series of verbal and physical altercations with other residents and staff. Despite his decision, he later connected with researchers and expressed his gratitude for their advocacy on his behalf in the larger service provision system as well as his satisfaction with

Both researchers and residents documented discussions in formal interviews and focus groups, LEAP researchers' meetings, LEAP advisory board meetings, staff focus groups and key informant interviews with management. We compiled these data and discussed them in community advisory board meetings and LEAP researchers' meetings to create resident-driven programming. The evolving programming comprises three components: a) administrative leadership (e.g., joint staff-resident Welcoming Committee for new residents, LEAP advisory board membership, LEAP researchers' group attendance), b) meaningful activities (e.g., art collective and art space, writing groups, gardening, outings, game nights, potlucks, poetry readings, talent shows), and c) pathways to recovery (e.g., individual and group harm-reduction treatment, talking circles, mindfulness meditation groups).

The meaningful activities became a focal point and required a coordinator, whom LEAP advisory board members hired with greatest deference to resident members' input. That residents hired staff to deliver the programming they had developed was a transformational process and was cited by residents as key for their investment in the programming and the larger research effort. The meaningful activities coordinator is continuously reassessing residents' expressed interests in developing new programming and in reshaping and tailoring existing programming. Residents and staff have begun to colead and independently lead meaningful activities as well. One example is maintaining hours in the art space, which residents and the activities coordinator his representation of his values and concerns in the research process. The researchers often reflect on his important contributions to the process and remain very grateful for his involvement. transformed from a mostly unused room into a safe, creative space where visual, written, musical and Native artistic traditions are practiced side-by-side.

Interpreting and disseminating findings

Researchers worked together with residents, staff and management to complete assessments for a small (N=118), nonrandomized controlled pilot study examining the effectiveness of this approach in reducing alcohol-related harm and improving quality of life compared to Housing First programming as usual in two other DESC housing projects. Participants experiencing the resident-led programming reported engaging in significantly more meaningful activities than participants who received programming as usual. Within-subjects analyses indicated that participants receiving resident-led programming also drank significantly less alcohol and experienced fewer alcohol problems after programming was introduced.[5] More important, residents have talked about how the programming and their involvement in the research process have helped "build community," "changed the ecology" of the house, and contributed to personal growth. We are currently qualitatively analyzing the CAB meeting transcripts to reflect longitudinal changes in the partnership and processes. As a group, we have disseminated research findings through symposia and posters at scientific and housing conferences, talks at community events, and community panels in university classes. Over time, researchers have included community members on grant-funded studies as research consultants to recognize their knowledge and skills, including

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[5]These outcomes take into account both residents' preference for a harm-reduction perspective and the alcohol research field's accepted means of measuring alcohol use and related problems.

their CBPR expertise, their lived experience, and their work on our boards and as peer-leaders in research roles.

Conclusions

CBPR is a research framework that—compared to traditional, researcher-driven paradigms—more equitably involves communities and their constituents in research that addresses health disparities, particularly in marginalized populations. Although it has been most closely associated with other fields (e.g., public health, nursing), CBPR traces some of its roots and practices back to the field of psychology, such as Lewin's (1947) action research and Bronfenbrenner's (1979) ecological systems theory. It is also compatible with psychology's ethical principles and practices. Recent research has shown that the use of a CBPR framework in guiding projects can improve their internal and external validity as well as the effectiveness of interventions, programming and policies developed within these projects. Although there are key ethical considerations that must be addressed in conducting CBPR, psychologists are well-positioned to conduct this work, given our strong traditions and emphases in ethical and best practices, client-centered approaches, interpersonal communication, and scientific rigor.

Perhaps the most important point, however, is the potential positive, collaborative, power-shifting and transformative impact psychologists can be a part of through CBPR. In the words of one community consultant and author (JS) who reflected on the CBPR process: "How do you put into words the power of being given one's voice? The satisfaction of having addressed a situation within a community. The comradery, the brotherhood, the sense of belonging. These elements produced an environment that promoted positive growth. [We had] many voices within a challenging set of circumstances that not only identified problems but negotiated solutions through individual views by addressing community concerns and needs. Participating in this process has been very enlightening, incredibly rewarding, and in my case Life changing. I am very grateful for what I am able to take away from this. Thank You." That gratitude is shared by all authors of this manuscript. We thank each other for showing up, being persistent, staying open, asking questions, engaging in colearning, solving problems, telling our stories, and most important, nurturing our communities.

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Table 1

Components of the Research Process in the Nonpatient-centered Research and Community-based Participatory Research Approaches

	Traditional, nonpatient-centered research	Community-based participatory research
Researcher-participant relationship	• Individuals are approached by researchers without necessarily addressing community's stated interests. • Researcher relationship with thecommunity is minimal and based primarily on a researcher-participant relationship. • Participants are considered "human subjects."	• Community approaches researchers or both are engaged over the longer-term due to mutual interests, shared community involvement and/or long-standing research engagements. • Researcher relationship with participants and communities is developed over time. • Community members have official status on community advisory boards and potentially as co-investigators.
Research idea or question	• Research questions stem from a professional imperative to contribute to generalizable scientific knowledge. • Researchers generate ideas. • Research questions are driven by funding priorities and researchers' academic interests.	• Research questions stem from a social justice imperative that emphasizes the need to address health disparities. • Research ideas are identified by or in collaboration with the impacted community. • Research questions are driven by the community's expressed needs.
Funding	• Funding is sought out and secured by the researchers. • Funding is designated for the specific research project only.	• Communities and researchers may work together to secure research funding. • Funding is available for current research, longer-term engagement, and community capacity building.
Oversight	• Approving authority is the institutional review board (IRB) at the researchers' institutions. • Oversight is meant to protect rights and welfare of "human subjects."	• Approving authorities include an IRB from the researchers' institutions and those protecting the well-being of the community (e.g. tribal IRB, community advisory boards, steering committees). • Communities' oversight is meant to protect their values, ethics and interests.
Research Design	• Preset design does not change over the course of the project. • Although some qualitative research may be conducted, researchers use primarily 'objective,' deductive and quantitative methods.	• Design may be more flexible to accommodate an iterative research process, especially in early phases. • Community input is valued. • Researchers use inductive methods and practice reflexivity, acknowledging that subjectivity is inherent to all research.
Intervention design	• Researchers design interventions and programming to be tested within research projects. • Interventions and programming are designed based on evidence-based practice and the current state-of-the-science.	• Communities codesign interventions, often via their participation on community advisory boards, on steering committees, and in consultant roles. • Interventions and programming are designed based on researchers', stakeholders', and community input

	Traditional, nonpatient-centered research	Community-based participatory research
		and reflect scientific and clinical standards as well as the community's interests, knowledge and values.
Data collection	• Researchers choose measures. • Measures are selected based on their psychometric properties (i.e., reliability/validity, specificity/sensitivity) established in prior research studies. • Research staff recruit participants and collect data.	• The community provides input on the selection of measures and/or co-designs locally specific measures in addition to standard instruments. • Community members may choose to assist in recruitment and data collection.
Data analysis	• Researchers are solely responsible for data analysis planning, implementation, and interpretation.	• Community expertise and perspectives are solicited and valued in planning analyses, analyzing data and/or interpreting findings.
Publication/ Dissemination	• Researchers and/or their institutions have sole intellectual property claims on research • Research is disseminated primarily to an academic audience. • Advancement of researcher/institutional interests is the primary consideration.	• Community members are often co-authors/co-owners of research products. • Research is disseminated in multiple formats and across various types of venues to be accessible to the community as well as to academic audiences. • Community well-being is a priority and may be advanced in various ways (e.g., community-wide adoption of developed interventions, trainings, policy recommendations and actions).
Sustainability	• Programming and interventions are only implemented within the research timeframe and are discontinued after the research project has ended. • Researchers do not make data and findings available to the community and/or key stakeholders.	• Plans for sustaining programming/interventions designed during the research timeframe is built into the research timeline and funding. • Data/findings are available to the community for future funding requests, regardless of researcher involvement. • Researchers work with community beyond a single funding cycle.

Note. Some researchers have summarized the distinction between traditional research and CBPR approaches (e.g., Horowitz, Robinson, & Seifer, 2009). Prior comparisons, however, were not made from the psychology researcher perspective. Here, we compare CBPR and traditional psychology research processes, whichexposes and challenges some of the fundamental and often implicit assumptions in traditional psychology research. It should be noted, however, that these contrasts are meant to be illustrative and are not absolute, prescriptive, or accurate in all cases.