

## Community-Academic Collaboration and Ethics-Concepts, Principles, and Processes: Building on the Center for Promoting Health and Health Equity-Racial and Ethnic Approaches to Community Health

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### ABSTRACT

This paper employs a literature review, an ethical/philosophical analysis, and authors experience to develop a framework for guiding community-academic partnerships in collaborating to pursue health equity. The framework involves dynamic and interactive categories of Core Concepts, Guiding Principles, and Key Processes. Core Concepts are that collaboration involves partners in-relation who walk and explore together, ethics involved throughout. Guiding Principles are to honor community rights and well-being, primarily promote community health equity, secondarily advance academic interests, ensure justice throughout, and sustain principles involving mutuality (respect, transparency, authenticity, trustworthiness, care, humility (cultural and epistemic/knowledge), and solidarity). Key Processes are periodic reflexivity with framework critical review; deliberation, discussion, and decision; and negotiation and conflict resolution. The literature review only addressed publications in English. Most articles focused on the United States, as does much of the authors experience. Thus, the analysis could overlook aspects that a more global examination might reveal. Thus, the framework is provisional.

**Keywords:** Collaboration; Partnership; Ethics; Health equity; Community; Academy

### Introduction

Community-academic collaborations to advance health equity are burgeoning. Typical objectives are community health improvement through research and evidence-based interventions. For such collaboration, this paper analyses and explains a framework of (1) core concepts, (2) guiding principles, and (3) key processes.

As community and academic partners, we developed our account on published literature and insights from our successful initiative to reduce health disparities by enhancing physical activity of African Americans in Omaha, Nebraska (described below). Our community-academic partnership is the Center for Promoting Health and Health Equity (CPHHE), housed at Creighton University in Omaha.

CPHHE Background. Established in 2008, sustaining funding for CPHHE is a Creighton University allocation of resources from The State State of Nebraska Change Health Care Funding Act (LB 692) that support measures to reduce health disparities. CPHHE promotes health equity through community outreach, grant proposals for reducing health inequities, and faculty and student training in health disparities research. CPHHE by-laws require a community member chair and a community majority among the partners, typically 11 community and 10 academic partners. CPHHE partners have developed growing mutual respect, trust, and understanding over a decade [1].

Author Backgrounds. Author Jackson was the original Community Partner Chair and overall CPHHE Chair. He is a public health professional with the (Omaha area) Douglas County Health Department, was President of the Omaha NAACP (National Association for the Advancement of Colored People), and is a community activist and leader. Author Lassiter is a Community Partner and recent CPHHE Chair. She has directed and initiated Omaha and Nebraska programs targeting infant mortality reduction, Nebraska's Healthy Marriage Initiative and Teen Pregnancy Prevention

Programs, is former President of the Nebraska Minority Public Health Association, and is a community activist and leader. Authors Kosoko-Lasaki and Stone co-founded and co-direct CPHHE. Kosoko-Lasaki, Principal Investigator for the CPHHE-REACH project, is professor and physician (Department of Surgery) with a master's degree in public health and national and international experience through multiple grants in promoting health equity. Stone is a physician and philosopher, Professor Emeritus at Creighton University (Graduate Faculty, Master of Science in Bioethics; Department of Medicine, School of Medicine) and previously core faculty with the Tuskegee University National Center for Bioethics in Research and Health Care. He has worked on numerous grants and projects to advance health equity.

CPHHE-REACH Initiative Background. In response to a Centers for Disease Control and Prevention (CDC) request for proposals, CPHHE drew on its existing partners, other Omaha leaders, and Creighton University personnel, forming the "Center for Promoting Health and Health Equity-Racial and Ethnic Approaches to Community Health" (CPHHE-REACH) initiative. CDC funded the four-year initiative, designed and conducted in a cooperative agreement with CPHHE-REACH. The initiative's overarching objective was to prevent or ameliorate chronic health problems through policy, system, and

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environmental improvements that promote physical activity. REACH is a national CDC program “to reduce racial and ethnic health disparities by strengthening capacity and implementing evidence and practice-based strategies [1].” Interested readers should also see “Urban Minority Community Safety and its Impact on Physical Activity [2].”

CPHHE-REACH implemented evidence-based approaches to enhancing access to physical activity, especially through “Community Health Ambassadors” (CHAs) who were prepared through a train-the-trainer model. CHAs prompted changes in community partner facilities to create or enhance physical activity opportunities.

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In developing the initiative proposal, CPHHE drew on prior experience training CHAs as health advocates. With community partner input, the proposal was drafted with partner deliverables. Proposal leaders (PI (author Kosoko-Lasaki), other key personnel) oversaw, partly wrote, and revised drafts. CDC funded the proposal and advised changes; proposal leaders modified the initiative accordingly.

CPHHE-REACH community partners represented African American churches, Omaha Public Housing Authority (public housing towers), the Urban League of Nebraska (centered in Omaha), Charles Drew Federally Qualified Health Center (CDHC, majority of clients African American), and the Douglas County Health Department (as instructor/trainer). Other participants were CHA trainers from the Creighton University School of Medicine (CU-SOM). Collective for Youth, an after-school program, was also a partner. Community partners and CU-SOM trainers provided monthly updates and project suggestions. An external community advisory group gave quarterly input. CPHHE-REACH also gathered community input through community focus groups and health assessment [1]. The Creighton University Institutional Review Board’s judgment was: “This project has been determined to be exempt from Federal Policy for Protection of Human Subjects as per 45CFR46.101 (b) 2/3.”

## Materials and Methods

In light of our CPHHE and CPHHE-REACH experience, we scanned the literature regarding ethics and collaboration in community-academic partnerships targeting health. We also drew on relevant ethical and philosophical accounts. We further built on our professional knowledge and community experiences that included awareness of communities’ justified distrust of the academy; history of community exploitation by academic institutions; and influences of racism, ethnic bias, socioeconomic inequalities, and cultural divides. Authors Kosoko-Lasaki and Stone had published in these areas [3,4].

Technically, our approach is a supplemented “scoping review.” As Munn and colleagues explain, “The general purpose for conducting scoping reviews is to identify and map the available evidence [5].” We reviewed a wide range of literature that referenced a much broader literature. Thus, we are reasonably confident that we found the predominant themes, if not every subtheme. The following section

“maps” our findings, combined with our own analysis.

In literature searches regarding collaboration and community partnering, we considered reports about research and evidence-based implementations or interventions. We mainly employed PubMed with the “snowball” approach, reviewing sources in initially identified articles [6]. Key search terms were “collaboration,” “ethics and collaboration,” and combinations with “CBPR” (community-based participatory research), “health equity,” and “health disparities.” We included CBPR because we knew the method is a prominent way to promote health equity and reduce health disparities through community partnering [7,8]. We mainly considered articles in the 2000’s because the relevant literature is exploding and those reports could direct us to older material. After scanning titles and selected abstracts, some 80 publications were initially reviewed in more detail. Then, after a subsequent search, we reviewed some 25 further publications.

## Results and Discussion

Publications addressing CBPR typically mention “collaboration” regarding community and academic or researcher partnering, but only sometimes elaborate what collaboration means and should include. Collaboration is basically joint effort for some purpose(s) [9]. Community-academic collaboration for health equity is a complex enterprise with multiple relationships among diverse partners. Our take of the literature and our experience is that such collaboration can be usefully divided into the following three dynamic/interactive categories, from the more abstract to the operational (Figure 1).

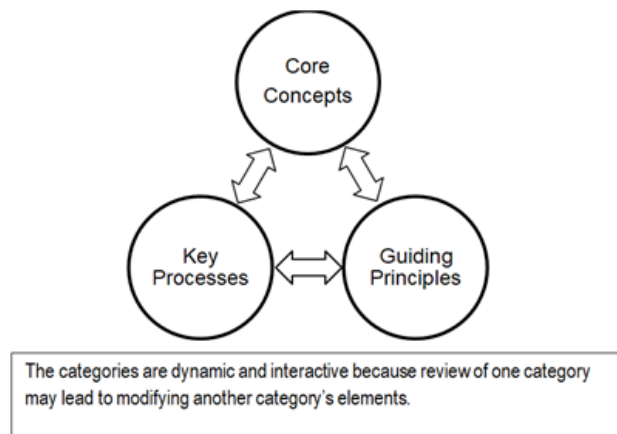


Figure 1: Dynamic and Interactive Categories

- Core Concepts
- Guiding Principles
- Key Processes

The categories are dynamic and interactive because review and reflection in one category may lead to modifying another category’s elements. On this point particularly see the discussion of “reflexivity” in the Key Processes subsection (3.3.1).

Core concepts

Collaborating community and academic partners function “in-relation” and ethically by “walking” (personal communication to Author 1 from Luis Marcos) or “exploring” together [10] (Table 1).

**Collaborating partners are in-relation**

This core concept builds on the work of Jean Baker Miller and Judith V. Jordan, among others [11]. This scholarship includes analyses of “Women’s Growth in Connection,” the title of one of their co-edited collections with colleagues [12]. Individuals in-relation function interdependently; personal qualities matter. Janet L. Surrey emphasizes empathy’s crucial role: “The ability to be in relationship appears to rest on the development of the capacity for empathy in both or all persons involved [13].” These features and requirements reasonably apply to collaborative partnerships.

The “in-relation” concept pertains to partner attributes and interactions. Collaborators are connected and interdependent, working together to achieve group aims and objectives. Individual partners’ effectiveness in group efforts depends, for example, on others’ cooperation, openness to alternative ideas and forms of expression, and awareness of partners’ emotional states. In community-academic collaborations, partners are often diverse by virtue of life experiences related to racial/ethnic identification, gender, sexual orientation, occupation or profession, education, discipline, expertise, positions, cultural, and socioeconomic factors. These differences affect partners’ power and how they use it, all influencing how participants function in-relation. Do participants dominate or facilitate deliberations? Do

they ensure everyone has a fair opportunity to contribute? Do they have humility that fosters listening and openness to others’ views? How partners function in-relation has significant implications for all following elements.

**Collaboration for health equity involves ethics throughout**

Health equity itself is an ethical goal and a feature of justice [14]. Health equity includes fair opportunity for health and fair health status outcomes. Health equity excludes unjust health disparities. (Some writers take health disparities as intrinsically unjust or inequitable. Since “disparity” per se only means difference, we add the “unjust” qualifier to avoid confusion.) Collaboration to pursue health equity should also be equitably conducted, including through project/research implementation and results dissemination. Later sections elaborate ethical aspects of collaboration in principles and processes.

Partners walk and explore together. Clearly partners travel together through time in pursuing shared purposes. Understanding such travel as “walking together” resonates with the “in-relation” concept. Collaborators are connected and progressing. And collaboration is often a discovery journey about not only each other, but also about partnership directions, opportunities, challenges, and so forth [10].

**Guiding principles**

Compared to concepts, principles are more specific guides for community-academic collaboration. Principles generally indicate what collaborators should do and how they should be. Like other elements here, principles are provisional. Collaborators can revise or

Core Concepts	Guiding Principles	Key Processes
1-Collaborating partners are in-relation 2-Collaboration involves ethics throughout 3-Partners walk and explore together	1-Honor community rights and well-being 2-Primarily promote community health equity and secondarily advance academic interests 3-Ensure justice throughout 4-Sustain multiple principles involving mutuality -Respect, Transparency, Authenticity, Trustworthiness, Care -Humility, Cultural, Epistemic, Solidarity	1-Periodic reflexivity 2-Critical review 3-Deliberation, discussion, and decision 4-Negotiation and conflict resolution

**Table 1:** Categories and Elements: Community-Academic Collaboration and Ethics.

reject any element here, provided good reasons support changes. Note that guiding principles in theory could support actions or decisions that other guiding principles might oppose. In such cases collaborators must determine which principle(s) to follow through appropriate deliberative discussions (Table 2).

**Honor community rights and well-being**

Collaboration should uphold community rights and well-being [15]. After all, the collaborative focus here is community health equity and health is a feature of well-being. But what are community rights? Moreover, basically, do communities have rights? Although answers to these questions are a matter of some debate, see Mikesell and colleagues’ 2013 literature review of ethics in “community-engaged research [15].” They found that many publications advocated not only ensuring each community member’s rights, but also “community autonomy” or “self-

determination.” The literature also supported that researchers should prevent individuals and the community from “harm and exploitation.”

Braveman and colleagues explain that health equity and health disparities, related to justice, are connected to human rights [14]. But that individual humans have rights does not necessarily mean communities have rights. And whether communities have rights is not a trivial philosophical question. If communities lack rights, then what basis is there for claiming they are owed something? A partial answer is that flourishing communities are the foundations for human well-being and development. It is well-known that research or implementation projects only targeting individuals can harm or exploit whole communities.

**Primarily promote community health equity and secondarily advance academic interests**

In community-academic collaborations for health equity, the two partner groups may have both identical and different agendas (sometimes expressed as primary and secondary interests). Both groups' main function is to advance community health. But members of each partner group will have other legitimate interests. For example, community partners might want to build on the collaboration to develop other projects to meet community needs. And academic partners may reasonably want to leverage partnership membership to develop other fundable grant proposals and promotion and tenure. Both groups' success in reaching such other goals can reverberate so as to enhance the collaboration. However, such secondary interests should not undermine achieving the collaboration's primary interest in community health equity.

### **Ensure justice throughout**

Justice is the foundation of health equity [14] and covers all collaboration. For example, justice as fairness dictates that usual collaborative discourse and negotiations should include everyone's "opportunity and authority to exercise agency [16]." Based on their survey, Mikesell et al. (2013) advise that historical community abuse generates current ethical obligations to the community. Also, they emphasize "community justice" that: "in CBPR is often understood as the process of negotiating compromises between researchers and communities to ensure fairness for both individual study participants and communities [15]." An example is equitably sharing financial support between community and academic institution.

### **Sustain mutual respect, transparency, authenticity, trustworthiness, care, cultural humility, epistemic (knowledge) humility, and solidarity.**

We list this principle's components together because they all involve a mutuality, ways that partners should treat each other and interact. Mikesell and colleagues' (2013) survey identified that "ethical collaboration "requires...true mutuality. Such as through engagement, sharing of experience of leadership, transparency, and mutual empowerment [15]." We think "true mutuality" involves deep and abiding respect among all collaborators. Respect includes honoring and upholding everyone's dignity and worth. Further, respect includes empowering others and ensuring all have conversational space. Transparency prevents hidden agendas that can undermine collaborative aims and objectives [16]. Transparency relates to authenticity-partners are who they present ourselves to be, a feature of integrity. Ninomiya and Pollack found significant literature support for developing "authentic relationships [17]".

A related crucial value is collaborators' trustworthiness, drawing on LaVera Crawley's analysis [18]. Trustworthy partners can be counted on to mean what they say, do what they promise, and support the partnership's purposes. Trustworthiness builds trust and trust helps bind collaborators. Transparency and authenticity reinforce trustworthiness. If collaborators repeatedly show they are who they seem to be, trust follows.

Historically, academic institutions and researchers have often exploited communities with disadvantage. Thus, trustworthiness that builds trust is paramount in community-academic collaborations. As current author Author Stone and bioethicist Annette Dula argued, historical and continued abuses and trauma are good reasons racial/ethnic minorities should reasonably (or "rationally") distrust health professionals and researchers. But, "trustworthiness promotes conversion of 'rational distrust' into 'rational trust [4]." And Author Stone and Dula proposed that a primary ethical principle in addressing

trust and trustworthiness is "equal and substantial respect" that includes treating people with "equivalent and significant recognition and regard".

Care is another crucial principle in collaboration that we next explain in detail. Although extensive literature addresses notions of care and philosophical accounts of ethics of care, our literature scan did not reveal direct attention to care as a value for collaborative community-academic partnerships [19].

We earlier stressed the core concept that partners are "in-relation." Care involves how people do or should relate, evolving out of feminist ethical analyses. However, "care" has different meanings [19]. For collaborative partnerships, our focus is on care as the tendency or disposition "to be attentive and sensitive to other people's needs and willingness to help them [19]." Characterizing this type of care as a virtue, for Gheas "care is a general attitude, opposed to callousness and indifference to the needs of others [19]." Our care principle, then, is that partners should seek to exemplify care as a virtue. They should intend to be sensitive, attentive, and empathically attuned to each other. Instrumentally-to promote collaboration toward health equity-care attributes builds mutual rapport, respect, empowerment, and trust. Care is a further way to honor participants' worth and dignity.

Cultural humility. Community and academic partners are often multiply diverse by virtue of culture, socially constructed gender and race/ethnicity, nationality, locales of origin and development, socioeconomic factors, education, knowledge, discipline, expertise, and multigenerational trauma and injustice, including through colonialization. We agree with others that Melanie Tervalon and Jann Murray-Garcia's cultural humility approach is a key element for constructively addressing such diversity [20-22].

Tervalon and Murray-Garcia's early work on cultural humility targeted problems in educating medical students and physicians to apply a very problematic concept of "cultural competence" in patient care. Regarding what they termed "multicultural medical education," they wrote:

"Cultural humility incorporates a lifelong commitment of self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individual and defined populations" [20].

The authors' thick concept of cultural humility, some features above, stands behind the principle of cultural humility we espouse for community-academic collaborations. For example, cultural humility should promote equitable relationships intrinsic to CBPR and Tribal Participatory Research.[22] Cultural humility works against the tendency of institutional researchers to think, without community input, that they sufficiently understand a health inequity issue and what should be done about it.

Bava et al. emphasize consideration of diverse "frames of meaning" and perspectives [23]. Regarding knowledge and "expertise," Brunger and Wall underscore epistemic humility and promoting partners' epistemic authority, that all "have equal authority and legitimacy" regarding knowledge [24]. Diversity is multifaceted. Collaborators must cultivate a humility that enhances their openness to varied perspectives, disciplinary approaches, beliefs, and traditions.

Epistemic (knowledge) humility. We advocate Ninomiya and Pollack's advice to "practice humility, and integrate Indigenous ways of knowing into research" [17]; such efforts support decolonization.

They also stress moving beyond standard academic or disciplinary boundaries. For example, some disciplines' knowledge norms may discredit other fields' epistemic criteria and motivate undervaluing community partners' knowledge and priorities [25]. Furthermore, in 1998 Israel et al. wrote that knowledge paradigms particularly fitting "community-based research" are "critical theory," with several options, and "constructivism" [26]. Exploring and updating relevant theories of knowledge is beyond the present scope.

Solidarity includes "empathy toward persons more distant" and "concerns for the needs of the most disadvantaged [27]." And "solidarity directs that we should have such feelings of connection, alignment, fellow feeling, and the like for others far and near [27]." Care and solidarity both emphasize connection that can and should apply to co-collaborators. Care conceptions typically involve physically close relationships, although not always. But "distance" can characterize gulfs of life experience, priorities, and much more. Across such gaps, solidarity is a complementary concept to care. Note that Yassi et al. emphasize caring and solidarity [28].

This outline of guiding principles could have been much longer. For example, we might have also addressed compassion and loyalty. Compassion is somewhat different than empathy that care includes. But long lists add further complexity and pose diminishing returns. But we noted earlier that our schema is provisional. Partners can and should regularly review this guidance.

**Key processes**

We discussed core concepts and guiding principles that we conclude should serve as foundations and guides for key collaboration processes that include deliberations, discussions, negotiations, decision-making, and reflexivity-based reviews by whole group and possibly subgroups. We suggest the following should be core features of key processes, but they can be further specified or modified (Table 2).

**Periodic reflexivity**

Durable and effective collaborations must regularly review their fundamental concepts, principles, and key processes, as well as goals, aims, and objectives. "Reflexivity" is the apt process because core features include critical and inward-turning examination that can reveal new understanding and suggest refinements that promote positive growth.

A significant literature addresses reflexivity in a spectrum from single researchers to teams, organizations, and communities [29-32]. Most useful for our purposes is Wendel and colleagues' 2018 paper about what they termed "critical reflexivity of communities" regarding health improvement, and their exploration of background concepts in reflexivity [33]. As they explain, "reflexivity practiced collectively is a social process and context dependent." Also, "organizational structures or systems must promote or facilitate the reflection or engagement necessary for learning to occur." A key element is facilitated critical review (see next process).

Regular reviews are crucial for flourishing collaborations because through time and experience, participants' understanding can grow, new insights may emerge, and changing contexts potentially pose bring new issues or challenges. Thus, the existing framework and intended outcomes can need changing or expanding. Also, problematic issues or behaviors may need negotiating or otherwise addressing. And community-academic collaborations should employ ad hoc reflexivity when circumstances require. But such as-needed considerations should build on regular formal reviews of everything from core concepts through goals, aims, and objectives. Depending on the group's duration and history, we suggest the following provisional reflexivity timeline: Table 2 Of course, collaborators can and should modify reflexivity timelines as situations dictate.

Duration of Collaboration	Review Type
Month 6	Condensed
Year 1	Detailed
Year 2	Detailed
Year 3	Detailed
Year 4...n	Detailed

Reflexivity involves collaborators' periodic review their fundamental concepts, principles, and key processes, as well as goals, aims, and objectives. Table A.1 is a suggested timeline, but collaborative groups should determine what is best for them.

**Table 2:** Reflexivity Timeline (Provisional).

**Critical review**

Although reflexivity is a process, we earlier detailed the principle of reflexivity and related processes to stress reflexivity's normative, non-optional status. But reflexivity can be further specified. A core element is initial and periodic critical review of everything from core concepts through goals and objectives. Critical review might include the following categories with sample questions:

- Understanding: What do we think ... means (e.g., trustworthiness the word and as a principle)? Do we need more education about ...?
- Knowledge perspectives: Are people's varied knowledge

parameters causing confusion? If so, what should we do [34]? Guillemin and Gillam (2004) stress critical reflection about "the kind of knowledge produced from research and how that knowledge is generated [34]."

- Completeness: Should we add any concepts, principles, or processes? (For example, see many specific principles that Thomas et al. report [22].)
- Revisions: Should we revise any aspects of ...?
- Integrity: Could our interactions better reflect solidarity? Are power differences adversely influencing what we do?
- Errors: Have we been mistakenly applying or interpreting ...?

- Foundations: Do the new (or changed) context, background, or information require new or revised operating procedures about...?
- Lessons learned: Regarding ....., what did we learn from our successes and failures?
- Challenges: What challenges are greatest? What strong barriers are we overlooking [35]?

Our CPHHE-REACH experience built on preexisting CPHHE community-academic partner relationships. We mainly assumed collaborators tacitly agreed about guiding principles and related aspects. We never ensured overt examination. In contrast, we would now explicitly aim for reflexivity and periodic critical review.

#### **Deliberation, discussion, and decision**

Guiding principles discussed above all involve how community-academic collaborators ought to interact. Power and other differences can pose major challenges. Regardless, effective and acceptable forms of communication for addressing issues and reaching decisions are crucial needs. Following a significant literature, we advise employing these basic elements of “democratic deliberation”: (1) providing reasoned bases for positions, and (2) ensuring all can understand those reasons [36]. These elements welcome many forms of communication, including emotion-laden statements. Regardless of how expressed, participants can legitimately ask others to explain, through comprehensible reasons, why the others should agree. However, we recognize that cultural differences might influence what participants take to be acceptable reasons. Thus, many issues may need significant review to achieve general agreement, if agreement can be reached. Other decision aspects include whether and how to pursue consensus, follow majority approval, and resolve differences.

#### **Negotiation and Conflict Resolution (NCR)**

We understand negotiation generally as a process in which people with different positions, understandings, etc. discuss issues and aim to reach agreement about them. If successful, discussants arrive at a conclusion that is mutually understood and accepted-conflict resolution [37]. Community-academic collaborations pose many dimensions of difference such that participants should negotiate and then, hopefully resolve conflicts. One example reported CPBR participant needs to negotiate what justice implied for the project [38]. More generally, Mikesell et al. found many references in the literature to “Community justice, which in CBPR is often understood as the process of negotiating compromise between researchers and communities to ensure fairness for both individual study participants and communities engaged in research [15].” Elaborating on their findings, Mikesell et al. further write that “ethical CBPR requires ongoing dialogue and negotiation with communities.” Ross et. al emphasize that in community-academic research partnerships, negotiations must be respectful and fair [16]. Reviewing meanings and strategies for NCR is beyond the present scope. However, we emphasize that NCR needs will doubtlessly arise in community-academic partnerships. Thus, leaders should consider familiarizing themselves with basic NCR elements and identifying skilled facilitators to assist when needed.

#### **Conclusion**

This paper addresses what collaboration and ethics should mean in community-academic partnering to promote health equity. Given a diverse literature and issues, a clear framework is a resource for partnership functioning grounded in ethics. Our analysis yielded categories of Core Concepts, Guiding Principles, and Key Processes.

Core concepts are that partners in-relation walk and explore together, ethics involved throughout. Guiding principles are: Honor Community Rights and Well-Being, Primarily Promote Community Health Equity and Secondarily Advance Academic Interests, Ensure Justice Throughout, and Sustain Multiple Principles Involving Mutuality-Respect, Dignity, Worth, Empowerment, Transparency, Authenticity, Trustworthiness, Care, Humility (cultural and epistemic), and Solidarity. Key Processes are Periodic Reflexivity with Critical Review of all framework elements; Deliberation, Discussion, and Decision; and Negotiation and Conflict Resolution.

#### **Limitations**

The literature review only addressed publications in English. Most articles focused on the United States. Thus, the analysis could overlook aspects that a more global and culturally diverse examination might reveal. The authors’ experiences and racial and cultural backgrounds may importantly limit their perspectives. These limitations are reasons we stress that the framework is provisional and that critically reviewing it through periodic reflexivity is essential. Epistemic humility demands this approach.

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