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Untangling Neoliberalism's Gordian Knot: Cancer Prevention and Control Services for Rural Appalachian Populations

George F. Bills

University of Kentucky, appalachia01@yahoo.com

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George F. Bills, Student

Dwight Billings, Major Professor

Keiko Tanaka, Director of Graduate Studies

UNTANGLING NEOLIBERALISM'S GORDIAN KNOT: CANCER PREVENTION
AND CONTROL SERVICES FOR RURAL APPALACHIAN POPULATIONS

DISSERTATION

By
George F. Bills
Lexington, Kentucky

A dissertation submitted in partial fulfillment of the
requirements of the degree of Doctor of Philosophy in the
College of Arts and Sciences
at the University of Kentucky

Director: Dr. Dwight Billings, Professor of Sociology
Lexington, Kentucky

2013

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Abstract of Dissertation

Untangling Neoliberalism's Gordian Knot: Cancer Prevention and Control Services for Rural Appalachian Populations

In eastern Kentucky, as in much of central Appalachia, current local storylines narrate the frictions and contradictions involved in the structural transition from a post-WWII Fordist industrial economy and a Keynesian welfare state to a Post-Fordist service economy and Neoliberal hollow state, starving for energy to sustain consumer indulgence (Jessop, 1993; Harvey, 2003; 2005). Neoliberalism is the ideological force redefining the “societal infrastructure of language” that legitimates this transition, in part by redefining the key terms of democracy and citizenship, as well as valorizing the market, the individual, and technocratic innovation (Chouliaraki & Fairclough, 1999; Harvey, 2005). This project develops a perspective that understands cancer prevention and control in Appalachia as part of the structural transition that is realigning community social ties in relation to ideological forces deployed as “commonsense” storylines that “lubricate” frictions that complicates the transition.

Keywords: cancer prevention and control, Appalachia, Neoliberalism, social networks, discourse

Untangling Neoliberalism's Gordian Knot: Cancer Prevention and Control Services for
Rural Appalachian Populations

By

George F. Bills

Director of Thesis

Director of Graduate Studies

Date

(To Sheilla and Denver – You have been my anchor)

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Chapter One: Opening Thoughts

Untangling Knots in Communicative Sociation

The illocutionary forces constitute the knots in the network of communicative sociation: the illocutionary lexicon is, as it were, the sectional plane in which the language and the institutional order of society interpenetrate. This societal infrastructure of language is itself in flux; it varies in dependence on institutions and forms of life. But these variations also embody an innovative mastery of unforeseen situations (Habermas, 1987, p. 321).

What appears from one perspective to be the formation, maintenance, and/or dissolution of social ties among community members appears to be a plot twist, change of direction, or story resolution from another perspective. The influences communicative processes have are expressed in the ways actors commit to various storylines. In eastern Kentucky, as in much of central Appalachia, current local storylines narrate the frictions and contradictions involved in the structural transition from a post-WWII Fordist industrial economy and a Keynesian welfare state to a Post-Fordist service economy and Neoliberal hollow state, starving for energy to sustain consumer indulgence (Jessop, 1993; Harvey, 2003; 2005). Neoliberalism is the ideological force redefining the “societal infrastructure of language” that legitimates this transition, in part by redefining the key terms of democracy and citizenship, as well as valorizing the market, the individual, and technocratic innovation (Chouliaraki & Fairclough, 1999; Harvey, 2005). This project develops a perspective that understands cancer prevention and control in Appalachia as part of the structural transition that is realigning community social ties in relation to ideological forces deployed as “commonsense” storylines that “lubricate” frictions that complicates the transition.

Preventive healthcare is among the institutions and forms of life being restructured within this new service economy. In part, health promotion has emerged as part of a “technological fix” to deal with escalating health care costs and the breakdown of national consensus about how to manage and maintain the expansive biomedical industrial complex. At the same time, it is also part of the hollow state, which means that its services are unevenly distributed across a mixed economy that includes a hierarchy of providers, from elite, for-profit private hospitals, spas, and other services to non-profit health clinics that primarily serve the poor and indigent. The hollow state has very few

command and control mechanisms and, as a result, public managers have sought to develop social networks to gain advantages of scope and scale without the negatives associated with bureaucracy (Milward & Provan, 2000). This organizational restructuring aimed at reducing bureaucratic redundancies, like redundancy and rising costs, and has been one of the main concerns of advocates for smaller government and privatization.

Yet health care service provision has not responded as projected. Ideally, networks of providers have been developed to deliver contracted services rather than relying on bureaucratic orders of civil servants. Costs have continued to rise. The other intended gain here was supposed to be potential for flexibility to change and adapt as need change. This allows the risk involved to be reduced because, when needs change, contracts can be terminated quickly. This makes service provision for populations like those with chronic diseases dangerously unstable when that provision is subsidized by public funds or is so high that it creates massive debt for many of us if we are to receive needed services. The move to a network-based infrastructure has had consequences for the public sphere as well, since third-party agents must organize themselves politically to pressure elected representatives to intervene in disputes between the government agency and its network of nonprofits and firms or continue to provide subsidies needed to continue service provision to marginalized populations (Milward & Provan, 2000).

Prevention's status as a sub-discipline in biomedicine is ambiguous in that it is often promoted in academic and policy circles as a cost-reduction strategy that decreases the long-term likelihood that targeted populations will suffer expensive chronic illnesses, yet this outcome is in conflict with the profit-taking made possible by expensive technological interventions focused on prolonging life in the face of later stages of disease. At the level of clinical practice, recipients are expected to engage with the expert knowledge that is part of the discourse, regardless of how ambiguous or contradictory it may be. They must discern what activities this knowledge supports regardless of how out of place it might be within current lifestyles. And, they are expected to commit to enacting prescribed activities on a daily basis, sometimes with little guidance to know when the practices are working, how long they should be continued, or whether or not third-party payment sources underwrite interventions. It is no wonder that many proponents of prevention and health promotion have focused on changing how financing

for prevention is enacted in order to bring financial incentives in line to support the promotion of screenings and other prevention interventions

Health promotion is, then, organized around the prevention and elimination of particular diseases or destructive lifestyle patterns that include the planning for, and execution of, educational and other health practices like screenings, communal participatory rituals like health fairs and fun runs, and, of course, fund-raising activities. These rituals and ritual cycles are carried out for specific periods of time during the year, but are also repeated across time from year to year as seasonal promotions. Relay for Life, for example, takes place in late spring, although its planners start organizing events in January. October has become Breast Cancer Awareness Month and is adorned throughout the month with pink ribbons and other fashionably pink paraphernalia.

I am concerned, then, with how cancer prevention health promotions, as seemingly mundane social practices in modern America, participate in making Neoliberalism commonsense. Cancer prevention has become ubiquitous in our time. It includes practices which, by virtue of their penetration into many areas of our lives, carry an air of the commonplace. The institutional forms that go along with cancer prevention tend to be accepted and taken for granted as part of seasonal changes in the US. It is my contention that these commonplace practices not only carry expectations associated with expert knowledge about cancer into our daily lives, but also import changing expectations about how we should participate in decision-making that affects our lives. Cancer prevention activities are depicted as concerned with the expression of individual identity and often utilize participatory social forms as part of its practices.

Cancer prevention activists utilize coalitional politics to accomplish their ends, and I want to trace the flow of intentions through what Habermas (1987) calls the “knots in the network of communicative sociation” among prevention groups to understand how cancer prevention rituals attempt to shape intentional health behaviors in communities in the face of growing “health disparities”. In doing so, I will also explore how Neoliberalism has “colonized” health decision-making and systematically distorted communication around the issue of cancer prevention. Teasing apart these knots involves making analytical distinctions among organizations, the actors that represent them in the community, the activities which bring actors and organization together in cooperative,

competitive, and conflictual relations, and the genres of discourse through which they communicate internally within the organization as well as externally to those outside the organization. Actual material relations unfold over time and establish social structures. Following Fairclough (2001), actors, organizations, activities, relations, and discourse come to form an “order of discourse”:

Social practices networked in a particular way constitute a social order – for instance, the emergent neo-liberal global order referred to above, or at more local level, the social order of education in a particular society at a particular time. The discourse/semiotic aspect of a social order is what we can call an order of discourse. It is the way in which diverse genres and discourses and styles are networked together. An order of discourse is a social structuring of semiotic difference – a particular social ordering of relationships amongst different ways of making meaning, ie different discourse and genres and styles (p. 232).

Additionally, I want to explore what happens when the genres cancer prevention discourse in face-to-face communication are translated and recontextualized as part of news media stories in local newspapers. This involves examining relationships among clusters of stories over time in terms of the themes that structure their core arguments as well as examining relations between stories and the social action context in which they occur to understand what narratives can be told and which ones are left untold. These relationships are not simply matters of accurate representations of “the facts” of cancer and cancer prevention in the region, but are also mythical and ideological. Frye (1990) asserts that “myth” and “ideology” are idioms that deal respectively with “primary concerns” and “secondary concerns.” In stories of gods, societal history, and social structure, myth creates “a sacred ground” through words. These stories center communal meaning and identification on “primary concerns,” such as housing, clothing, food, and sex. They express what a society believes “ought to be” and point to what is universally important to us all. In this sense, Frye's notion of myth resonates with Habermas' ideas about communicative action. In contrast, “secondary concerns” are the basis of ideology. Ideologies are concerned with the best ways to obtain the items that make up “primary concerns.” They attempt to define the “way things are” and negotiate acceptance of these conditions as the best we can expect, given the circumstances. They privilege some interests and diminish or ignore others. Here, too, we see a resonance with Habermas in that ideological meaning involves instrumental rationality. Intentional activity emerges

from the tension between our efforts to find and maintain a center based on shared communal meaning and identification and rationalized concerns about how we will achieve and maintain our material well-being.

Research Questions

My research questions, then, include the following:

1. Who interacts with whom as part of the social practices of local cancer coalitions in eastern Kentucky?
2. As a result of these interactions, who become the central, and hence, more powerful, actors?
 - a. How do patterns of centrality shape larger network patterning in terms of clustering of ties and clique formation?
3. Does the clustering represent potential for public dialogue about cancer and its place in the region, or do the clustering patterns reproduce professional and organizational hierarchies?
 - a. What are the political consequences of clustering and clique formation?
 - b. Is there a Neoliberal ideological basis to power asymmetries?
4. Do similar clustering patterns emerge in the ways actors and organizations are represented in newspaper stories about the local healthcare social world? If not, what is the difference and are the patterns related in any way?
 - a. What genres of discourse can be discerned in stories about cancer prevention and control and how are these related to the kinds of cultural products the networks produce?
5. Where, when, and around what issues do patterns of cooperation, competition, and/or conflict emerge?
 - a. Which expert voices represented in newspaper stories and how are they represented? Which expert voices are validated?
 - b. What vision of the present and future do they represent? What is their relation to the cancer prevention and control mainstream? What is their relationship to environmental issues? What is their relation to technology?
6. How is Neoliberalism implicated in the reproduction of the region? How is this process maintaining or changing regional identities? What mythological themes

can be discerned as well?

Methodology

I used a mixed methods approach to untangle several “knots” in communicative sociation and follow the flow of intentionality that shapes how people understand themselves and the communities in which they live through cancer prevention practices. This approach included a grounded, critical ethnography (Carspecken, 1994). As I will discuss in Chapter Two, I was able to interview public health officials and/or coalition members from all sixteen counties as well as do participant observation in several different coalition meetings. I gathered social tie information from coalition members through two different social network inventories. I attended Ladies Day activities in Knott County and other promotional activities through the sixteen counties. Also, I read and analyzed coalition newsletters and the annual newsletters published by the Kentucky Cancer Program (KCP) for any information I could gather about coalition activities and who interacts with whom. This data was used to reconstruct coalition social networks from the twelve counties that have coalitions.

At the level of local newspaper discourse, I used Access World News (NewsBank) to find 137 relevant newspaper articles from the Harlan Daily Enterprise newspaper. Available in electronic form beginning in 2003, I sampled from the March, 2003 when I found the first relevant cancer prevention story until February 2010. Keywords searches included “cancer” and “cancer prevention as well as coal-related environmental using the keywords “environment”, “water quality”, “sewer”, and “roads” - all issues I knew from discussions with regional residents are related to the destruction mountain-top removal (MTR) creates. I also did organizational searches for “Kentuckians for the Commonwealth” and “fiscal court”, dropping fiscal court stories not related to the issues of interest.

Chapters five and six discuss my analysis of the story set that included 91 health-related stories and 46 environmental stories. The health-related stories were sorted into four categories, including stories associated with American Cancer Society (ACS), Harlan Appalachian Regional Hospital (HARH), and Harlan County Health Department (HCHD), and a fourth category I called “Profiles”. These are stories which may or may not have organizational affiliations with the three main organizations mentioned above,

but tended instead to focus on “profiling” some exceptional individual who has responded heroically to cancer. Environmental stories focused on public works projects in Harlan county, stories about mountaintop removal mining, coal mine related accidents, and the environmental organization, Kentuckians for the Commonwealth.

Cancer Prevention in the Context of Regional Development

Appalachian communities continually struggle with contradictions in the economic development process whereby they must “give away the farm” in order to get businesses and industries to settle in their localities, only to find that the resulting jobs rarely provide a livable wage much less provide benefits like health insurance. In the mean time, traditional sectors like mining provide fewer and fewer jobs while the technological “innovations” in mining wreck greater and greater environmental havoc. Trapped in this “treadmill of production,” the mining industry has instigated a variety of political and promotional campaigns to create the appearance of “grassroots” support for the industry and shape regional economic identity (Bell & York, 2010). Appalachia has seen a number of other efforts to mobilize local support for programs to address social problems through coalitions, including drug addiction and environmental pollution. These mobilization efforts share the fact that powerful outside interests have sponsored them to achieve their own political and policy ends. The coalitions promote responses to the social problems which tout individual responsibility as a means to deal with the issues of concern, and none of them promote economic redistribution or the radical institutional change to change power relations among central and peripheral groups in the region.

Eller (2008) points out that the consumer benefits of the modern culture have come to the Appalachian in the form of “big-box” stores like Wal-Mart and increased access to modern healthcare facilities, but with these benefits have also come environmental destruction, the displacement of millions of rural residents due to environmental destruction and declining employment, as well as the loss of traditional values and cultures. Improved quality of life, including access to quality health care, is part of the promise of economic prosperity which is touted as the goal of economic development practices, yet that promise remains unfulfilled in much of eastern Kentucky as traditional industrial sectors like coal mining scale back employment. The new service economy offers only low-wage, low skilled jobs in the region. The tendency in dialogues about the

economic prospects of the region has been to blame the land, environment, and culture of the mountains rather than challenge the national discourse on the meaning of progress and the most suitable paths to development.

The legacy of healthcare development in central Appalachia has been one that embraced collective action through the struggles of unionized miners to have quality healthcare and, similarly, for local communities to embrace community-based and feminist models of organization to create local clinics that put its patients' needs at the forefront of decision-making. Nationally, what started in the 1970s as feminist collective action to radically democratize women's reproductive healthcare and provide cancer screenings services responsive to the needs of local communities has morphed into a segment in a massive mixed economy of public and private research institutions, healthcare providers, and advocacy organizations. Like many areas of policy-making in US politics, healthcare generally, and women's healthcare particularly, have become polarized by party politics and ideological posturing. At the same time, many conservative political leaders have embraced a political rhetoric that opposes "big government", preaches a need for "fiscal restraint", and resents any government involvement in healthcare financing. These politicians have been actively deploying market-based solutions to healthcare distribution and want to defund what they see as "big government" intrusion into personal decisions about women's health. Eastern Kentucky, once dominated by New Deal democratic politics, has largely shifted politically right of center to embrace a number of conservative political leaders, suggesting that many local communities have accepted the "commonsense" of neoliberal political thinking and the policies that it embraces.

The rituals related to cancer prevention are typically initiated in eastern Kentucky by local public health departments in support of efforts to address cancer health disparities in the region. They typically include cooperation among various partner organizations and participation by a variety of community members. This move toward public-private partnership has been accompanied by a language of political participation through consumption that sees the citizen-consumer as expressing his or her political preferences through the purchase of goods and services, through participation in walk-a-thons and 5-K races, and through donations to causes and campaigns. Whether or not cancer

prevention coalition activity in this environment is actually emergent from bottom-up, “grassroots” collective action, or is part of top-down institutional policy initiatives from national and state health organizations, is a matter for empirical investigation. I will use ethnographic research on the social rituals of cancer prevention as a starting point to explore the interrelationship among discourses about cancer and public health that circulate in eastern Kentucky to explore if and how cancer prevention activities echo hegemonic, neoliberal themes about democracy and citizenship in our larger culture, and in turn, redefine the identity of the Appalachian region that has been changing in the course of the economic transition from and industrial to service economy.

Observing the Lay of the Land: Chapter Summaries

Seven chapters follow this one. Chapter one introduces a number of theoretical concepts in an effort to conceptualize cancer coalitions not just as a system for delivering preventive healthcare interventions, but also as a cultural vehicle that institutionalizes and ritualizes how these interventions are delivered, while chapter two develops preliminary understandings about cancer prevention coalitions as interorganizational social networks that serve as an infrastructure to support both the biomedical and cultural levels of intervention. In developing this understanding, I will discuss features of the complex history of the sixteen counties where this research was conducted that is typically omitted from medically-oriented research on the region. I will examine county-level cancer rates in light of recent conflict over coal production in the area, local grassroots activism in the same counties, and in relation to representations from local print news media of the region. In particular, examining the Tri-County Coalition (which is made up of members from Knox, Laurel, and Whitley counties) will illustrate both the proximity of the region of interest to much of the mountaintop removal mining in the region and to show how coalition building becomes a site for “regionalized action” (Giddens, 1984; Carspecken, 1994). I hope to show, finally, how discourses of coal, grassroots activism, media about the region, and public health issues like cancer, together, are reconfiguring the regional identity of central Appalachian in relation to neoliberalism.

Chapter three advances an understanding of cancer prevention in Appalachian Kentucky as a medical problem and a social problem. I also expand the use of social network analysis to visualize connections across coalitions to demonstrate spatially how

these coalitions help to institutionalize a particular cancer prevention discourse over other alternative discourses. By identifying local coalitions as “community-based” and “grassroots”, a chain of equivalences (Laclau, 1996) is established that reframes populations at risk for cancer in the region as worthy of subsidized financial support for their medical issues. The coalition discourse becomes part of a tradition of using “discourses of uplift” in Appalachia in an attempt to bring indigenous populations in line with Modernist development projects (Billings, 2000). The discourse of community participation solves “the problem of justification” for policy interventions (Boltanski & Thevnot, 1991; Sulkenen, 2009), while also operating as a “governing image” (Room, 1978) that provides social rubrics and specific models for shaping how cancer prevention will be enacted regionally are part of a top down participatory approach to cancer prevention.

Chapter four presents a rather straight forward network analysis that examines how space impacts cancer screening referrals. In this particular case, colon cancer screening referral initiates a kind of “package delivery process” (Borgatti, 2005) in which a medical practice sends a patient to a fixed destination (in rural areas, usually a local hospital which has the necessary laboratory capabilities) for screening – a decision based on several assumptions about route choice. I use regression analysis to suggest that distance does impact referral rates. I discuss how issues of distance impact local common sense understanding about how long it takes for someone or something to get from one site to another within the region and that this understanding impacts where high rates of screening occur.

To summarize to this point, chapter two through four works through the first three research questions mention earlier. They explore features of the coalition networks themselves, recognizing how, as sites of “regionalized action” (Giddens, 1984); stated differently, *networks are understood as the means by which the flow of intentional activity around cancer prevention is configured spatially along specific institutionalized lines*. This activity is shown to be deployed within a top-down, neoliberal model of participation that avoids disturbing the existing social order and displaces local consensus from community members to central organizational actors who are positioned to control the flow of information and resources about cancer prevention through preferential

attachments to other coalition actors.

In chapter five, I use Social Worlds Theory (Strauss, 1978; Unruh, 1979; 1980; Clarke, 2005), Critical Discourse Analysis (Fairclough, 2003) and Centering Resonance Analysis (CRA) (Corman, Kuhn, McPhee, & Dooley, 2002) to tease apart the “orders of discourse” in cancer prevention activities (Foucault, 1971) and social networks that are represented in 91 health-related stories and 46 environmental stories from the Harlan Daily Enterprise newspaper, a daily newspaper from one of the sixteen counties I researched. In Kentucky, the Kentucky Cancer Action Plan and Kentucky Women’s Cancer Screening Program (KWCSF) involve several organization genres which give cancer prevention practices in Kentucky a determinate structure, realizing biomedical practice associated with cancer prevention through state level instrumental social systems. If the Lifeworld is predominantly organized by communicative rationality and communicative interaction, Lifeworld experiences must involve genres that do not have such a determinate structure and are dialogical and heteroglossic (Fairclough, 2003).

Though much of the health promotion activity of the Early Detection and Cancer Screening Activism (COA) lays claims to a “grassroots” or Lifeworld basis, I argue that grounding cancer prevention activities in KWCSF and its guidelines actually give the COA a Systems-centered ordering principle with the power to “colonize” Lifeworlds rather than allow them to “speak truth to power”. Whatever dialogue might exist in the community about cancer and public health - “sensitive issues” (Warren, 2006) like the health effects of surface mining on coal communities - are constrained within a monologue derived from expert discourses on cancer prevention that frame cancer prevention as an individualistic activity.

It follows that a basic problem for a discourse analysis of the cancer prevention is not confuse the tendency towards organizational genres in public health institutions with local genres of concern about health threats and well-being. I attempt to sort genuine expressions of community sentiment from promotional culture (Wernick, 1992; Fairclough, 2003) that hijack survivor narratives in service of “tell-and-sell” texts (Fairclough, 1992) that disguise a sales pitch within medical information giving. Otherwise failing to see cancer prevention discourse as an historically-situated genre, a researcher can over-privilege the purpose of the mainstream cancer prevention message

as a research focus, inviting one to fall prey to ideological tendencies in the broader political culture to legitimize what Habermas calls the “pathological” over-extension of systems and instrumental rationality into the lifeworld – in his terms, the “colonization” of the lifeworld.

Chapter six examines how coalitional politics (Walby, 2001) and competition for media attention by community organizations establish a meaning horizon which delimits what can be said and known about cancer prevention, and which authorizes as true certain meanings and knowledges at the expense of others. This amounts to a “politics of truth” at play in mediated debate which is central in the constitution of public health debate as a public sphere (Chouliaraki, 2005). Examining the thematic structure of the stories related to different cultures of action separately allows exploration of how historical definitions of issue elements were constructed, maintaining local expectations about healthcare, environmental, economic, and political issues, over the seven year period from which I gathered stories. The historically specific conditions represented by news stories do ideological work by naturalizing conditions and making them appear inevitable. At the same time, they also position certain organizational actors as authorities even as they diminish or exclude other actors.

The positioning of organizational actors as experts creates an illusion of dialogue. But focusing on what appears to be one of the more dialogical aspects of the stories, the direct reporting of quotations by local sources, reveals how choices made by news reporting in terms of whose discourse is directly represented and whose is paraphrased, summarized, or otherwise indirectly referenced as networks of relations, have the effect of mystifying power relations by collapsing social identities, relationships and distances, making local elite voices appear to be more “like us”. Direct references to sources are selective “representations of discourse” (Fairclough, 2003), rather than literal chronicling of local dialogue on a subject. These reporting strategies have the overall effect of rearticulating the relationship between the public and private sphere, making political issues appear to be individual issues rather than collective ones. I bring these two analyses, thematic structure and positioning, together by illustrating how social structures emerge from the stories positioning local and state government as central actors in the community, supported by the local health department and hospital, while

ignoring or minimizing environmental impacts of local coal production and restricting voices concerned with cancer prevention to a focus of lifestyle and individual responsibility.

In chapter seven, my purpose is to explore the political will – that is, the “prevailing social attitudes” (Duffy, 1992) - that influence the focus of health promotion in Central Appalachia, particularly in the face of efforts to facilitate local participation in cancer prevention promotions. I engage in an “intuitive exploration” that loosely maps features of several versions of Appalachian identity together as a mythic system (Langer, 1990; Seale, 2002). By this I mean that I make several intuitive leaps that allow me to bring together theoretical perspectives on the mythic nature of news media and attitudes about healthcare consumption to suggest how health prevention messages romanticize and mythologize preventive medical intervention as much as they persuade and inform. Drawing on the discussions of solidarity and power in local media discourse, Appalachians become the heroes and villains and victims in dramas about how cancer disrupts the lives of people from the region. Appalachian communities, like those in the various Harlan County stories I will report, are communities at risk, restored to equilibrium in part by the availability of biomedical intervention, but also through the strength of its other valued institutions – its schools, its county government, and the support of family and neighbors. In other words, the stories teach readers the attributes required for successful adaptation within local institutions.

Mainstream cancer prevention and cancer treatment narratives tend to valorize practices that deploy biomedical technical expertise. The central hero of the professional cancer drama is the physician, and his supporting cast includes nurses and allied health service professionals who act as “serviceable others” (Morrison, 1993; Sampson, 1993) that support the construction of doctor as hero. Within this storyline patients and their families are framed as victims of cancer in need of the guidance, expertise, and leadership the physician supplies. Patient narratives offer another collection of subject positions within this genre. Their struggle against cancer within the constraints of biomedical intervention is another form of romantic heroism. Eventually cancer patients can attain hero status as “survivors”, provided they maintain the prescribed stoic resolve, consume a range of “pink ribbon commodities,” and comply with the recommended

treatment practices of health professionals.

At another level of connotation, I also argue that some actors in local news stories engage in transgressive negative health behaviors, such as prescription drug abuse or overeating that leads to addiction, or transgressive environmental stewardship, particularly, individual level polluting of the local environment, such as throwing trash in local streams or allowing “straight pipes” to discharge sewage into local waterways. These “offenders” create another level of “serviceable others” (Sampson, 1990) for the broad heroic designs of cancer prevention discourse. While the relationship between health professionals and their patients weaves together an array of meanings around the economic relationships between the parties involved in the medical encounter, the relationship between those who seek to be members of the moral community of the healthy and those who engage in offensive behaviors operates at a sociological and political level that emerges as actors attempt to negotiate continued positions in the social order. Although many people seek expert information to supplement their abilities to self-monitor health behaviors and engage in continuous learning of expert knowledges, others may derive pleasure and excitement from courting risks. As such, risk courting - gambling, spousal violence, unprotected sex, overeating, drug or alcohol abuse, or other risky behaviors - arises from the kinds of everyday anxieties and ambiguities that emerge in the face of the contradictions between production and consumption described by Crawford (2000).

Summarizing chapters five through seven, then, address research questions four through six. They explore how local news media reflects a preference for particular organizational voices as expert sources over other sources, establishing the horizon of truth concerning public health issues that avoids linking environmental and economic destruction on the part of the coal industry to the quality of well-being in the region. Organizational actors who send representatives to the cancer coalitions like the American Cancer Society and the Appalachian Regional Hospital in Harlan compete for voice in local media, promoting themselves as opposed to the local cancer coalition. Where as chapters two through four explore *spatialized regional action*, chapters five through seven explores *the trajectories of cancer prevention-related events represented in local print news to understand how identities are positioned in relation to one another temporally*.

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Chapter Two: Constructing Cancer Prevention, Constructing Appalachia

The Problem of Knowledge

...I contend as do Berger and Luckmann, that the sociology of knowledge is concerned with the analysis of the social, or cultural, construction of reality. Institutionalised interactions between people representing different groups in society can reveal how they take for granted certain things representing their 'reality'. They are also taking part in a social and cultural process where a concept such as prevention, for instance, comes to be socially established as 'real'. What is understood by both parties in the situation is based on a culturally created and implicit norm as to what health information is all about, coupled with the message centred on causality, responsibility and blame. Seen in this way, prevention is constructed out of communication in daily practice and action. Prevention is then a value or category that finds its expression in human interaction, that is to say, in a discourse on the individual and the social body, on blame, risk and threat (Sachs, 1996, p. 634).

In this chapter, I want to use a particular theory of knowledge that draws on the phenomenological and social constructionist traditions referenced by Sachs to understand cancer-related health information as it "is constructed out of communication in daily practice and action" by community-based cancer prevention coalitions. For me, one of the major challenges in studying cancer prevention is seeing past the notion that health knowledge is "simply the facts" about cancer as a disease to the ways that cancer-related health information includes normative claims about the social conditions surrounding the disease. Parties involved with cancer prevention construct a ritualized set of social practices to address cancer in the region "based on a culturally created and implicit norm as to what health information is all about, coupled with the message centred on causality, responsibility and blame." But, this knowledge also bears traces of the power relations and preferred institutional orders that shape how the condition is treated. Many of these traces follow from current Neoliberal assumptions about the hollow state and networked service provision. My goal here is to establish a theoretical starting point to see cancer prevention as "a value or category that finds its expression in human interaction, that is to say, in a discourse on the individual and the social body, on blame, risk and threat" and to explore how this discourse is shaping regional identity in central Appalachia.

Habermas' (1971; 1983; 1987) theory of knowledge-constitutive interests and his theory communicative action offer theoretical perspectives that attempt to understand

knowledge construction as more than a relativistic preference while maintaining awareness that the knowledge construction processes are generally in flux. Knowledge construction is subject to change via new scientific discoveries, or through questioning the underlying ideological biases in existing knowledge (Habermas, 1971). Habermas recognizes three knowledge-constitutive interests, which he calls technical, practical, and emancipatory. The technical knowledge interest is concerned with human “work”, and encompasses any interactions with the physical world. It is associated with the objectivist belief in “reality-in-itself”, the belief that reality is structured in a law-like manner independent of human intervention. This is the level at which a great deal of cancer knowledge is constructed, providing what are perceived as factually accurate accounts of cancer causes, risks, and treatment.

The practical knowledge interest is concerned with the interpretation of language and intersubjective communication. It is also associated with the constructionist belief in meaning as interpreted, understood, and shared. At this level, cancer knowledge is often used to support group participation as well as the social aspects of prevention rituals like Ladies Day at public health clinics. Such events strive to attract women for screening through an offer of free cancer screenings and through the distribution of “incentives” like complimentary beauty products for women. Professional friendliness on the part of staff attempts to the atmosphere around receiving a mammogram or Pap smear as non-threatening as possible. Cancer treatment and post-treatment practices recommend support group participation and valorizes survivor stories, while many cancer promotions attempt to build community participation in fund-raising activities through health “fairs” and other communal activities that seek to create a nostalgic remembrance of those who have succumbed to cancer even as they draw on idealized visions of community to make the gatherings family friendly.

The emancipatory knowledge interest is concerned with emancipation from manipulation and self-deception related to what Habermas calls the “colonization” of the Lifeworld. Emancipation dismantles the imposition of bureaucratic and economic processes onto the cultural ground that is the Lifeworld. The imperialism of business practices steered by Money or government bureaucracy steeped by Power drowns out local shared understandings and come to be taken as “common sense”. Emancipatory

knowledge provides a dialectical synthesis of, and a self-reflection on, both the technical and practical approaches to social life, including imperialistic claims made by business or government. It is here that claims made by cancer coalitions that their agendas are participatory and “grassroots” become open to empirical investigation. Does cancer prevention activity open its participants to new understandings of themselves, freeing them from the colonizing influences of the System, or does it merely patch together an infrastructure to prop up a failed mixed market for cancer medicine?

For Habermas (1971), communicative action is governed by practical rationality such that ideas of social importance are mediated through the processes of linguistic communication according to Lifeworld norms. Personal influence and shared understanding serve to reproduce and replenish the Lifeworld – and this practical rationality cannot be readily translated into the media of Money and Power. Instrumental rationality, in contrast to communicative action, governs systems of instrumentality including industries, or on a larger scale, the capitalist economy, and bureaucratic state government. Ideas of instrumental importance to a system are mediated according to the rules of that system, the most obvious example being the capitalist economy’s use of money, or the power that government bureaucrats deploy to get their particular economic or social interests recognized as common sense in mass media accounts of social problems. Self-deception, and thus “systematically distorted communication”, results when the Lifeworld has been “colonized” by instrumental rationality, so that social norms come into existence that legitimate money and power not otherwise justifiable within the terms of that Lifeworld. Colonization occurs when the means for mediating instrumental ideas gain pseudo-communicative power, as when a website claims it is reviewing health products for a specific disease or condition when in fact the site has been paid by a pharmaceutical company to present the company’s products as the primary solution to that particular health problem. Another example would be the use of financial or administrative resources to advertise some social viewpoint as objectively the best solution to a policy problem, as in current political ploys by political conservatives to undermine funding for contraceptive use as “fiscally responsible”. When people understand this as “consensus building” rather seeing it as situated application of an ideological point of view, the Lifeworld is said to have been “colonized” and

communication has been systematically distorted. The “colonization” metaphor is used because System steering media (i. e., money and power) are used to manufacture social consensus that is not native to the Lifeworld nor is it based on genuine communicative action. The examples above are based on decision-making processes from the systems of economy and political administration that have encroached upon the Lifeworld in a way that is both imperialistic and parasitic.

At this point, I want to extend the discussion of knowledge interests to consumer health information by making two conceptual leaps. These leaps will allow me to connect more concrete questions about consumer health information to Habermas’ knowledge interests. The leaps, however, are not intended to become thematic fixtures in the rest of the project, but are intended merely to illustrate the application of a particular theoretical position. They will allow me to suggest the kinds of dialogical, multiplex social and discursive ties through which intentions activate knowledge interests. The “dialogical” nature (Fairclough, 2003) of health prevention network ties will be the focus of later chapters as I blend methodological approaches descriptively to tease apart social networks and discourse networks related to cancer prevention in the eastern Kentucky counties where this research was conducted. The first leap will involve sorting kinds of health knowledge related to family well-being in terms of Habermas’ constitutive knowledge interests, locating questions of health and wellness squarely in the Lifeworld as opposed to individual psychology. From there I want to make a second conceptual leap so I might further differentiate knowledge interests in terms of their relationship to needs and human agency. I will do this by briefly discussing the issue of empowerment as it affects the ability of people to shape the stories they tell themselves and others to justify and legitimate their health behaviors. In making these leaps I will make a case for complimenting the study of cancer coalition activities with study of how cancer stories are represented in local print journalism, suggesting that both are relevant to guiding an analysis through the complex mesh of accounts that are available to the local communities as part of cancer prevention discourse.

Family Well-Being and the Lifeworld

The Lifeworld is “an environment described in terms of the customary ways of structuring the activities that take place within it” (Agre & Horswill, 1997, p. 1).

Lifeworlds evolve in order to facilitate the members' customary activities, and as they do, Lifeworlds help to "simplify life and reduce the cognitive burden on individuals" (p. 3). The evolution a Lifeworld helps to reduce both individual and collective cognitive loads by facilitating changes in long-term memory associated with schema acquisition and providing additional opportunities for the development of expert knowledge and performance (Clark, 2003; Lupart, Marini, and McKeough, 1995). Thus the Lifeworld is the "background" environment of competencies; solidarities and practices; and knowledges and attitudes that are represented in terms of one's cognitive horizon (Habermas, 1983; 1987). The concept was originally developed by the philosopher Husserl, who focused on consciousness, but Habermas grounds his notion of Lifeworld in the processes of everyday discursive communication, focusing how it consists of psychologically, socially, and culturally sedimented linguistic meanings.

The Lifeworld is thus the lived realm of informal, culturally-grounded understandings, relationships, solidarities, and personal competences. These understandings and accommodations are intentional, with the "illocutionary forces" of intentional activity constituting "the knots in the network of communicative sociation" (Habermas, 1989, p.321). Social coordination occurs by means of shared practices, beliefs, values, and structures of communicative interaction, which have an institutional basis. Individuals and interactions draw upon custom and cultural traditions to construct identities, define situations, coordinate action, and create social solidarity. Ideally this occurs by a communicatively achieved understanding, but it may also occur through pragmatic negotiations. Converse processes involve the rationalization and colonization of the Lifeworld by the instrumental agendas of bureaucracies and market-forces. The classic example of this colonization process has been the increasing intersection of medical encounters with professional systems of standards, state and federal regulatory schemes, and third-party administrative procedures necessary for surveillance and financial accountability.

Family life is typically interwoven with several kinds of "small worlds," (Chatman, 1999) - social environments where individuals live and work and where they are bonded together by shared interests, expectations and information. They also typically share a similar economic status and geographic proximities as well (Burnett, Besant, & Chatman,

2001). Families, likewise, are also embedded in local “storytelling neighborhoods” (Ball-Rokeach, Kim, & Matei, 2001). That is, they share stories about community life that shape neighbors’ sense of belonging within a given community. The shared Lifeworld and its networks of social ties, stories, and shared activities is the basic action context for Lifeworld understandings. Small worlds, and the storytelling networks that weave through and among them, circulate normative meanings such that “mutual opinions and concerns are reflected by its members’ in whom the interests and activities of individual members are largely determined by the normative influences of the small world as a whole” (Chatman, 1999, p. 213). Within a small world, everyday activities, including the processes of information access and exchange, are considered to be “the way things are,” and thus taken for granted by participants as being the standard across all small worlds, even when they are unique to a specific group. Small world groups, including families, shape what needs are perceived in relation to the action contexts actors must operate in, and thus impact what is understood as affecting family well-being. Competition among groups to define social problems often mean that class, racial, and gender differences among social groups are lost when some groups capture the definitions of a problem and control the resources deemed necessary for its resolution.

Baldwin (1996) has challenged frameworks for understanding family well-being that are based in psychological theories like that of Maslow (1987), who suggested that needs arise, develop, and are eventually met in a sequential order as part of a hierarchy of needs that are said to lead to self-fulfillment or self-actualization. This kind of conceptualization, according to Baldwin, omits important aspects of life, such as the human competencies essential for need fulfillment. I would argue that the competencies to which Baldwin refers are learned as individuals are socialized as autonomous agents through participation in various focal activities in different small worlds. A narrowly psychological approach paints a picture of family life as passive and apolitical, but a more adequate framework of family well-being understands human agency in terms of the knowledge-constitutive interests and communicative action necessary for interacting in various social settings as part of networks of communication and support. Actors may strive to maintain a normative sense of belonging, but are also capable of questioning, resisting, and even rebelling against historically situated arrangements if they are no

longer sufficient to meet important needs.

Family Empowerment and Knowledge Interests

In an earlier paper, Baldwin (1990) discusses “empowerment” as involving two interwoven issues: a) the development of human autonomy, and b) building and maintaining the public sphere. Her intention is to show family well-being and empowerment as a moral-political force – not just an act of individual agency. She refers to “power” as derived from the Latin *potere*, meaning “to be able”, suggesting that power is an ability, or, at least potential ability, which makes a person both able and competent to do something. This approach to family empowerment draws on political theory to discuss how power can also encompass power in authority, the ability to influence or persuade, the ability to act or accomplish something, and the ability to exercise control over others (Baldwin, 1996). To “empower” means that power or authority are *given* to someone, which, in turn, may involve the ability to act, to enable or to constrain oneself or others, to express oneself, or to make decisions on one’s behalf. Typically, in modern cancer prevention promotions the idea of empowerment focuses on the power of self-control or self-restraint to avoid dangerous health behaviors and to practice healthy ones, to use power to follow medical prescriptions or proscriptions, to use power to participate in “awareness activities” like fun runs and health fairs, and to use power to choose among options for contributing time and money to continuing cancer prevention activities like fund-raising drives. Those at risk can participate in making health care decisions about seeking screenings or deciding a course of treatment if it is needed. Radical confrontation of inequity and environmental degradation, or the rejection of such institutional forms as managed care, are pushed outside the frames of acceptable action in mainstream discourse of cancer prevention. Such discourses do exist, but they are typically found outside the culture of action associated with cancer awareness and screening activism (Klawiter, 2008).

In terms of the pragmatics of language, “power” would appear to be related to the kinds of “illocutionary forces” that Habermas has argued are constitutive of the “knots” of social ties that bind together not only the small worlds of the Lifeworld, but also the larger ties that shape region, state, and nation. By “illocutionary force”, Habermas (1979) is referring to the way that, in speaking, we not only make references to the empirical

world, but we also convey our intentions. Communicative competence involves the skillful representing of one's social alignments to various audiences as well accounting for one's actions in ways that appear plausible given those commitments. Semiotically, "power" is embedded in the field ("What is going on?"; "What is it about?") and tenor ("Who is taking part?") of the linguistic register and given form through the use of the generic types that characterize different social settings. Power is expressed partly through how the thematizations of meaning and identity are modalized in discourse (Fairclough, 2003). Story tellers express power through how information is encoded for presentation via types of signs as well as how information is assigned to the status of reality, or claimed by, signs, texts or genres. Power is intertwined with the representation of events and their temporal expression through plots and story lines in narratives (Törrönen, 2001). Importantly, categorizations between "Us" and "Them" are embedded in narrative story lines (Davies and Harré, 1990, p. 47). The categorical construction process can be traced through how subject positions are attached to temporal positions in the structure of plots by examining how the speakers value, with "pragmatic modalities"¹, actions under consideration (Sulkenen & Törrönen, 1997).

Methodologically, a strategy that analyzes texts dialogically for competition among voices in media teases apart the deployment of power in the construction of "the individual and the social body", and of "blame, risk and threat", uncovering how different voices are treated (or dismissed) as legitimate sources of news stories and events (Gamson, 1992; Gamson & Wolfsfeld, 1993). Social networks among actors and organizations based on affiliation with the thematic elements of stories can enhance the representation of the dialogic nature of media stories. Who is represented as competent to

¹ Within critical discourse analysis (Fairclough, 2001), modality is understood as part of a larger process of analyzing the institutional background of speech acts, and encompasses more than simply the identifying occurrences of overt modal auxiliaries - such as may, might, can, could, will, would, shall, should, must, and ought - in a text. Rather, modality concerns the writer's (or speaker's) attitude toward and/or confidence in the proposition being presented. In this method, modality is studied through analysis of certain linguistic features of a text, including types of main verbs, as well as through adjectives, adverbs, and certain nominalizations. According to Sulkenen and Törrönen, "for linguists, the logical treatment of modalities is too narrow, because it is centered on truth values of propositions. Linguistic analysis of modalities presents much more diversity in its problematics and approaches" (1997: 45). Their work draws on linguistic studies of modality located in a variety of linguistic sub-disciplines, including morphology, which describes the lexical forms in which modality is manifested in different languages; syntax, which describes the complex syntactic configurations in which modality may be manifested; and semantics, which identifies modal meanings and explores the variety of ways these meanings may be expressed morphologically, syntactically, phonologically, and pragmatically

act and who is represented as able to control and distribute necessary resources, shapes understanding in the public sphere regarding which parties provide families with solutions to disruptive situations like having cancer and who are relegated to a minor role in the process. The winners in the definitional process define the heroes and villains of local story sets, as well as shape perceptions of community risks and resolutions (Langer, 1998; Seale, 2002). While mainstream cancer prevention experts constitute definitional winners in local media stories about cancer, environmentalists concerned with the carcinogenic effects of mining constitute an example of actors and organizations whose definitions of cancer-related dangers are cast aside due to their inability to hold the media stage and capture audience attention.

Challenges to Family Empowerment around Cancer Prevention

The argument for family empowerment begins with the assumption that human beings, as potentially active human agents, have the ability to understand their needs and should have the power to define them and act upon that understanding. Because political and economic structures and processes promote inadequate and even distorted conceptions of society, however, empowerment is dependent upon the development of certain insights and upon reflective, critical abilities (Baldwin, 1990, p. 3).

Structures of power and domination can undermine family well-being in part through manipulation and systematically distorted communication (Habermas, 1970; Gross, 2010). In manipulation, “at least one of the participants is deceiving the other regarding the non-fulfillment of the conditions of communicative action which he or she apparently accepted” (Habermas 1983, p. 264). With systematically distorted communication “at least one of the participants is deceiving himself or herself regarding the fact that he or she is actually behaving strategically while he or she has only apparently adopted an attitude oriented to reaching understanding” (Habermas, 1983, p. 264). Manipulation is about deception of one party by another party in an interaction; systematically distorted communication is about self-deception. In manipulation, a boundary is crossed such that the goal of communication is no longer mutual understanding, but a goal that is deliberately hidden from one of actors (Gross, 2010). In systematically distorted communication, a boundary is also crossed in which the interactants deceive themselves. Interactants think they are in control of exchanges the purpose of which is mutual understanding, when in fact, they have allowed control to be taken over by something

external to themselves. In the cases of self and family, they give control over to other family members or internalized others; in the case of society, control is given over to the political order, to governments or to special interests.

Communicative action is governed by practical rationality, defined as ideas of social importance that are mediated through the process of linguistic communication according to the rules of a given Lifeworld (Habermas, 1987). Technical rationality governs instrumental action, like that found in various industries, the capitalist economy, or political bureaucracies. Instrumental ideas important to a system are mediated according to the rules of that system. This separation of spheres is essential to Habermas' theorizing because he wants to ground consensus in the everyday understandings shared among members of a Lifeworld, rather than the machinations of the corporate board room, political expediency, or an "invisible hand" of the market. Self-deception, and thus systematically distorted communication, is likely only when the Lifeworld has been "colonized" by instrumental rationality, so some social norm comes into existence and enjoys legitimate power even though it is not justifiable in terms of the assumptions of the Lifeworld. Colonization occurs when instrumental ideas gain communicative power, like when employers use the threat of firing to get a group of employees to stay quiet during a public debate, or when financial or administrative resources are used to promote a social viewpoint that has not gained legitimate consensus among various social groups. When people assume the consensus to be normatively relevant, the Lifeworld has been colonized and communication has been systematically distorted. The "colonization" metaphor is used because the use of money and power to arrive at social consensus is not native to the Lifeworld. Instead the decision-making processes of the System encroach on the Lifeworld in a way that is in a sense imperialistic.

Contributing to the potential for communicative distortion and colonization is the likelihood that actors bring to an interaction ideological biases that are reflective of their social group's values, prejudices, and class interests. Ideology represents individuals' relationship to the real conditions of their existence (Waitzkin, 1989). Ideology has an imaginary quality which patterns how individuals perceive and interpret their experience. This imaginary quality has already been implied in previous references to neoliberalism in the sense that neoliberal ideology uses the wholesale application of market metaphors

to re-imagine any social interaction it encounters as a market exchange. For Habermas (1970), science, too, is ideological in that it claims to be above ideology by insisting on its objectivity and value neutrality. As such, scientific ideology has increasingly been deployed by dominant groups to define a range of problems and make them amenable to technical solutions. The result is that scientific ideology tends to depoliticize social issues by removing them from critical scrutiny. Science, then, has the impact of legitimating current patterns of domination, including the class relations of production. Habermas (1970) calls this process of scientific claims-making “technocratic consciousness”, which tends to make a fetish of science. Technocratic consciousness becomes more irresistible and farther-reaching than older types of ideologies because the veiling of practical problems “not only justifies a particular class's interest in domination and represses another class's partial need for emancipation, but affects the human race's emancipatory interest as such (1970, p. 111)”.

Returning to Baldwin (1990), empowerment includes freedom from internal constraints on thought and action such as prejudice, lack of insight and knowledge, and the inability to take part in rational communication, as well as freedom from external constraints imposed by the social, political, and economic spheres of society. In other words, empowerment involves freedom from systematically distorted communication, ideological bias, and manipulation. This suggests that empowerment in consumer health information requires a process of learning that not only involves gaining knowledge of the technical and practical aspects of a disease and its treatment, - including the basics of its causal relations and the systems of treatment activities needed to change those causal relations - but is also capable of acknowledging the cultural, social, economic, and political forces that shape how the disease itself is defined and treated. What are the normative meanings of the condition? How are its meanings constructed and who is legitimated to construct and deploy those meanings? Are there forces complicit in manipulating understanding of the illness? Who encourages self-deception about the disease, its risks and consequences? Are there ideological processes at work making the class interests of some groups appear as “commonsense” rather than limited and particularistic? Are there self-destructive or social oppressive features of its origins or its systems of care that are distorted or minimized by ideological misrepresentation? These

are questions that are related not only to how families are tied to community networks of support, but also to other small worlds that intersect the family through work, community organizations, and local politics. They also are implicated in the ways health issues are represented in print news media and other electronic media, as well as through entertainment mediums. In this sense, emancipatory knowledge requires going beyond the direct information sources about cancer prevention offered by healthcare professionals to examine how that information is incorporated in news and other electronic media.

Chouliaraki (2005) argues that public debate in the media involves establishing a meaning horizon² delimiting what is said and known, and which authorizes as true certain meanings and knowledges at the expense of others. This amounts to a politics of truth at play in every mediated debate that is central in the constitution of the debate in a public sphere. There is a tight link between the politics of truth and the democratic potential of mediated debate, with the meaning horizon of the debate tied in many ways to the kinds of identity themes and the boundaries that help to establish, maintain, and assure support for the social dominance of particular social groups. The horizon also may distance marginal groups. Distancing may activate various “sensitive issues” (Warren, 1990) that “everybody knows” are impolite, or unfair, or otherwise destabilize the public conversation. Such disturbing and disruptive issues can take over the conversation and reduce the dialogue to name calling and innuendo, or it can be deployed manipulatively

² "Gadamer views understanding as a matter of negotiation between oneself and one's partner in the hermeneutical dialogue such that the process of understanding can be seen as a matter of coming to an 'agreement' about the matter at issue. Coming to such an agreement means establishing a common framework or 'horizon' and Gadamer thus takes understanding to be a process of the 'fusion of horizons' (Horizontverschmelzung). The notion of 'horizon' employed here derives from phenomenology according to which the 'horizon' is the larger context of meaning in which any particular meaningful presentation is situated. Inasmuch as understanding is taken to involve a 'fusion of horizons', then so it always involves the formation of a new context of meaning that enables integration of what is otherwise unfamiliar, strange or anomalous. In this respect, all understanding involves a process of mediation and dialogue between what is familiar and what is alien in which neither remains unaffected. This process of horizontal engagement is an ongoing one that never achieves any final completion or complete elucidation—moreover, inasmuch as our own history and tradition is itself constitutive of our own hermeneutic situation as well as being itself constantly taken up in the process of understanding, so our historical and hermeneutic situation can never be made completely transparent to us. As a consequence, Gadamer explicitly takes issue with the Hegelian 'philosophy of reflection' that aims at just such completion and transparency." Stanford Encyclopedia of Philosophy(2009), *Hans-Georg Gadamer*, <http://plato.stanford.edu/entries/gadamer/>

to silence marginal voices and force them to remain marginal to the conversation. If the politics of truth authorizes the meaning horizon in which the debate topic is construed, then, by assessing the contours of this horizon (what it includes and what it excludes as possible knowledge) we can assess the capacity of the public sphere to deliberate without becoming entangled in destructive attacks related to sensitive issues.

Exploring the networks of affiliations connected with stories about cancer prevention in local newspapers can be an enlightening way to explore how, over time, some issues get discussed in the news and others do not. We can also explore who is winning the competition to define local issues and how they connect to state and federal experts. The politics of truth are thus represented in terms of actors and organizations being recognized as having a voice and being lauded as representative of the community. An example from eastern Kentucky of what I am discussing here involves how identities like “survivor” are deployed in relation cancer prevention to describe how cancer patients are traumatized by the diagnosis and treatment for cancer. At the same time, however, there appears to be no equivalent discourse to describe how those traumatized by exposure to mountaintop removal practices - dangerous blasting that hurtles large stones, dust and mud slides towards nearby homes; speeding coal trucks that fly by family homes overloaded with coal; water supplies and wells tainted with mud, acid, heavy metals and other pollutants, to name just a few – handle the stresses of living in a coal producing county.

Two Personal Recollections on Culture and Growing Up in Appalachia

Recollection One

In this and the following sections, I want to utilize personal recollections about growing up in central Appalachia to introduce some of my assumptions about how healthcare and its technocratic interventions are understood within the Appalachian context. In recollection one I am concerned with dispelling the idea of the doctor-patient dyad as central to understanding medical communications. Though doctors do interact individually with patients they have always been embedded in larger networks of social ties, many of which have not had the best interests of patients at heart. The Appalachian setting has been one in which physicians were often employees of “the company” – the mining or timber company, railroad, etc. – or “with the state” – evaluating physicians and

psychiatrists working as agents for state welfare, rehabilitation, or other services. Many Appalachians have been wary of physicians as a result, fearing that their private information may be used against them by companies and the state to gain an upper hand in disputes and conflicts with the patient.

The second recollection introduces the notion that “invented traditions” (Hobsbawm & Ranger, 1983), “‘traditions’ ...invented, constructed and formally instituted...emerging in a less easily traceable manner within a brief and dateable period ... and establishing themselves with great rapidity.” Such traditions emerge in novel situations and take on the form of historic practice, but actually express power differences in a community, many times shaping local identities in deep ways. In many Appalachian communities these invented traditions bear the traces of class intra-state and intra-county differences, marking local boundaries between economic strata and status groups. Cancer prevention and control rituals have emerged as part of the recent “prevailing social attitudes” (Duffy, 1992) about healthcare accessibility, and, thus, carry many of the Neoliberal assumptions that have been reshaping how health care services are financed and delivered in the U. S.

In this first recollection, I want to focus on early experiences receiving healthcare from a company doctor in the community I grew up in. The community was founded in the late 1800s as a timber mill town and many of the original company houses still line the main street at the western end of the community. I was in the second grade at the time of my recollection and had been having problems with a deep chest cold that made me cough noisily. I was taken by my grandfather to see the local doctor, who for years had been the company doctor for a local timber company. My grandfather and his father had worked at the mill and, though I was obviously very sick, my grandfather still felt it was necessary to warn me that the doctor was able to spot a faker from a mile away, a necessary skill for the company physician of a timber mill.

I thought about this experience a lot as I began preparing for this dissertation project. Appalachian populations are often characterized in academic, development, and professional literatures as reticent and distrustful in the presence of outsiders, strangers, or professionals, particularly when the latter are not from the local area. Compliance/noncompliance, framed as willingness/unwillingness on the part of patients to cooperate with medical procedures, has been the technical name for such behavior.

Failure to trust medical personnel is often attributed in Appalachian patient populations to cultural malaise or fatalism. As an alternative to the characterological assessments of Appalachians, I considered ideas about social structure in sociology, usually attributed to Georg Simmel (Simmel, 1955; Ritzer, 1992), about differences between dyadic relationships and larger combinations of actors (like triads, networks, and reference groups) would appear to be relevant here. The problem with dyads, according to Simmel, is that they are inherently unstable and prone to dissolution over time. As typically framed, the only medical encounters discussed as relevant are limited to those involving the doctor-patient dyad. Each party is described as initially rational, each presenting him- or herself to the other in a way that maintains his/her identity. Dyadic instability has been framed in a particular way, assuming the physician operates from a high level of moral and professional ethics while presenting him- or herself in a non-manipulative manner. Patients are constructed as “non compliant” or “resistant” when they fail to cooperate with the physician, regardless of whether their actions are the result of ignorance, defiance, or legitimate concerns for privacy. Early “patient education” research on medical communications focused almost exclusively on such a dyadic conception of the medical encounter (Dixon-Woods, 2001).

Even a slightly larger pattern of relationships like the triad, gives us a different starting point for examining communication. Triads are relatively stable social structures, but they may include strategies on the part of one or more participants that lead to competition, alliances, or mediation. The triad is thus likely to develop a group structure independent of the individuals in it, whereas this is less likely in the dyad (Ritzer, 1992, p. 166). Two parties in the triad, for instance, can form a coalition against the third party, which then allows the coalition to leverage resources and influence to support their own ends. Additionally, coalitional control of the communication process can affect a kind of “discursive closure” that prevents genuine conversation (Deetz, 1992). This observation resonates with the experience I had with my grandfather and the company doctor that day when I was young and ill with a cough. Not only did I have a grandfather participating in the session, but the physician's nurse was there as well, each leveraging my need for support and approval to assure compliance with the rules of the medical encounter in my home community. For a person working in timber, coal, oil, gas, or steel in Appalachia in

the early to middle part of the twentieth century, employers were a looming presence behind each visit to the doctor. Getting caught shirking could damage a reputation as a reliable employee and possibly cause one to lose a job. Even as unionization increased worker's rights, and worker's compensation became available, doctors triangulated both with employers and the state to decide whose health was sufficiently poor to deserve compensation. Psychiatrists could also declare one's children deserving of a disability check if they experienced difficulties learning or behaving in school. This process of moral surveillance continues today, but it has been re-configured under Neoliberal assumptions not only among workers in the moral economy of production relationships, where credentialing and fee-for-services shapes the cost of time spent with a particular health practitioner, but also on the consumptions side as (bio)medical practice. Framed in terms of "consumer choice" within managed care networks, the range of topics that can be broached in a medical encounter has been re-configured based on limitations imposed by the kinds of third-party payment sources one has.

The typical dyadic framing of the doctor-patient relationships has been challenged in recent years as the medical community has attempted to incorporate participatory practices into its repertoires of action. Consequently, two discourses have emerged in the literature on how doctors use medical leaflets to communicate medical information to patients (Dixon-Woods, 2001). The first of these is more prevalent, reflecting the traditional dyadic framing of medical encounters. "Patient education" is the euphemistic concept that reflects practices that attempt to encourage patients to embrace medical priorities and comply with physician-focused decision-making by teaching patients technical knowledge about a condition and its treatment. Typically, this discourse invokes a mechanistic model of communication in which patients are characterized as passive and open to manipulation in the interests of a biomedical agenda.

The "patient education" discourse contrasts with an alternative discourse of "patient empowerment", which is more recent in origin. This second discourse draws on a political agenda of patient empowerment that is reflected in its stress on choice of patient-centered outcomes and mutual decision-making. It is concerned with the use of printed leaflets as a means of democratization. The two discourses, though distinct, are not entirely discrete. They have begun to be closer as they draw on a wider set of resources,

including sociological research and theory, to develop more rigorous and theoretically grounded approach to patient information leaflets. While traditional discourses concerning compliance maintained a direct focus on the doctor-patient dyad through the practices of “patient education”, participatory discourse uses the notion of “patient empowerment” to understand community participation as a facilitator of individual choice.

Still, the use of participatory practices and the language of empowerment is only a “buzzword” in many circles, and “participation” can actually have different meanings depending on whether or not participation and empowerment are defined from a “top down” or “bottom up” position (Mohan & Stokke, 2000). A neoliberal position is a “top-down” strategy for institutional reform. State agencies and collaborating non-governmental organizations are encouraged to engage in efforts to make institutions more efficient. Target groups are identified and included in the development process, but the neoliberal participatory strategy defines participation and empowerment within a “harmony model” of power. In this model, power resides with individual members of a community and can increase with the successful pursuit of individual and collective goals. The implication is that empowering the powerless can be achieved within the existing social order and without any significant negative effects upon the power of the powerful.

On the other hand, a Post-Marxist position, as Mohan and Stokke (2000) name it, is quite different from the neoliberal view. It involves a more radical notion of empowerment as a “bottom up” social mobilization in society. The authors appear to drawing on sociological and political traditions similar to those of Habermas (1983; 1987) in which mobilization challenges hegemonic interests within the state, and society. Marginalized populations are encouraged to achieve “conscientisation” and collective identity formation in response to economic and political marginalization. Power is conceptualized as relational and, thus, recognizes the potential for conflict. From this perspective, the empowerment of marginalized groups requires structural transformations of economic and political relations towards a radically democratized society. The participatory, “patient empowerment” discourse in health promotion often sounds like the Post-Marxist position, but in practice, many programs actually are structured in line with

a neoliberal position, designed to maintain harmony locally and to work within existing power relations.

The discourse of democratic participation emerged in health care circles with the Declaration of Alma-Ata, which was adopted at the International Conference on Primary Health Care (PHC) in 1978. The Conference made an urgent call for effective national and international action in the developing world to implement primary health care, particularly in third world nations. Conference members sought to urge governments, United Nations organizations like WHO and UNICEF, and other international organizations, funding agencies, and health workers to commit to primary health care as a fundamental right. Its goal was to channel increased technical and financial support to developing countries to improve health care through community medicine. The Declaration made ten non-binding points to member states including calls for economic and social development as a pre-requisite to the attainment of health, the active role of the State in providing adequate health and social measures, and increased community-based participation in shaping the health policies that affect them. Though I have not been able to verify a direct connection between the emergence of community-based involvement in cancer prevention and the Alma-Ata Declaration, community-based practices did gain credibility in the same historical era of the late 1970s, when both domestically in the US and internationally, tremendous economic and social upheaval began to undermine what had been a fairly long post-WWII consensus about the value of public good and the importance of a welfare state to redistribute resources under capitalist economic systems.

Alma-Ata and the emergence of community-based prevention models have become part of what historians call the “prevailing social attitude” of an era in which the US (Duffy, 1992). But this inclusion in everyday consciousness occurred during a series of transitions at different levels of society, including a transition from the New Deal Consensus that supported a strong welfare state to a Neoliberal Consensus that pursues radical “structural adjustment” to disembed economic markets from taxation and regulation that “interfere with” the free flow of capital. The current era also marks a transition from one of “medicalization” to one of “biomedicalization” (Klawiter, 2008). Medicalization utilized the development and deployment of individual-level diagnoses to mark unhealthy, “deviant” or “dysfunctional” identities via a “sick role”, which in turn,

(temporarily) restructured the marked identities in relation to the responsibilities and obligations of their social position. Biomedicalization, in contrast, generalizes the responsibility for illness and health to all populations, regardless of whether or not particular persons have medically legitimated diagnoses or not. Under the regime of biomedicalization, we are all continuously subject to a “duty to be well” (Greco, 1993) and, thus, must take personal responsibility for knowing the probabilities of risk of disease or injury that we are subject to, and for acting on this actuarial mindset in relation to our health and well-being.

Neoliberal practices of participation do not “rock the boat.” They do not upset local officials and power brokers in the same manner that social democratic, “bottom up” approach can. The neoliberal model assumes that actors enter a political arena with their interests fully formed, rationally making political choices in a manner similar to the kinds of choices consumers make in the marketplace (Mohan & Stokke, 2000). Actors, then, “spend” political capital by negotiating consensus sufficient to *gain a majority*, as opposed to engaging in consensus-building based on *acceptance of the force of an argument*. In health promotion, such consensus-building has the benefit of complimenting the “duty to be well” with calls for more “personal” responsibility on the part of target populations. Personal responsibility means rational “investments” of time and energy in selected health behaviors, investments which do not make demands on state and local business to support efforts through increased taxes or regulation. The individual is the risk-taker who invests in healthy behavior, hoping for a return on that investment in terms of continued good health. Failure to succeed is defined within the harmony model of power among rational risk-takers, making the failure personal, rather than collective.

Duggan (2003) states that the construction of a neoliberal hegemony in the US can be divided up into five phases:

...(1) attacks on the New Deal coalition, on progressive unionism, and on the popular front, political culture and progressive redistributive internationalism during the 1950s and 1960s; (2) attacks on downwardly redistributive social movements, especially the Civil Rights and Black Power movements, but including feminism lesbian and gay liberation, and countercultural mobilizations during the 1960s and 1970s; (3) pro-business activism during the 1970s, as US-based corporations faced global competition and falling profit rates, previously

conflicting big and small business interests converged, and business groups organized to redistribute resources upward; (4) domestically focused “culture wars”, attacks on public institutions, and spaces for democratic public life, in alliances with religious moralists and racial nationalists, during the 1980s and 1990s; and (5) emergent “multicultural,” neoliberal “equality” politics – a stripped-down, nonredistributive form of “equality” designed for global consumption during the twenty-first century, and compatible with continued upward redistributive resources (Duggan, 2003, p. XII).

It is the last phase that concerns me in this project. Specifically, my concern is how neoliberal “equality” politics have been imported into health promotion to become part of the practices of cancer prevention at the community level. Reframing the meaning of “equality” is part of a deeper attempt to utilize participatory practices as a technological “fix” when lack of resources gets in the way of the “utopia of endless exploitation” of healthcare market building; when local populations are too poor to continually access and utilize services; and when the system of access and referral breaks down. “Community participation”, “empowerment” and similar language can mask the consequences of structural contradictions and mystify the remedying the health care disparities. Ingham’s (1985) discussion of the “unique historical conjunction” of the times, whereby “State expenditures have increased dramatically since the Second World War” yet government spending fails to meet the raised expectations of recipients of State and local aid, is valid here. For many of the clientele of health care services in rural areas of Appalachia, real and relative deprivation is triggered by an inability to attain the lifestyle promoted by the marketing strategies of the purveyors of goods and services. The Hollywood depictions of the “good life,” that now come into many people’s homes via cable TV to all of the counties I studied, fuel perceptions that the region continues to lack something other areas of the country appear to be achieving.

Key Factors That Shape the Public Health Context

John Duffy (1992) outlines three factors that have traditionally shaped public health policy in the US and, thus, have left marks on cancer prevention and control. These factors include 1) the prevailing social attitude, 2) medical concepts that predominate at a given point in history, and 3) the role of government in a country’s economy changes.

The first factor affecting policy and practices in public health is the “prevailing social attitude” (Duffy, 1992). This attitude has come to manifest itself in a political tension

between “big government” and market-based privatization in popular culture, but also points to a deeply embedded structural tension in American democracy. The issue of health prevention over the past 50 years has been framed culturally in terms a conflict between personality features related to capitalist production and those related to consumption (Crawford, 2000):

Health promotion, including the conflicted and inconsistent adoption or rejection of medical prescriptions and proscriptions, can be understood as a ritual which attends to ‘matter out of place’: a contradiction in structure – at once material and symbolic – which is the source of a conflict in experience for contemporary Americans. Advanced capitalist societies are beset by a contradiction between production and consumption, which in its cultural form defines the parameters for crucial conflicts of individual behavior, morality and identity. Health promotion is meaningfully situated on an ‘axis of continuity’ with the cultural contradictions of capitalism – an axis in that those contradictions and their experiential conflicts “meet and converge” in health promotion and continuity because the two domains of experience have ‘family resemblances and connections’. I am proposing that the collectively fashioned, mutually recognized, and endlessly rehearsed predicaments of attempting to improve health in a world of apparently unhealthy enticements provide a template for our larger predicament (Crawford, 2000, p. 221).

We can read this tension through one lens that is attuned to the demands on families in the US to balance public obligations to take care of personal health and the welfare of dependent children and elderly with the desire for lifestyles that families find emotional satisfying (Cherlin, 2010). Another way to read this quotation is through the lens of what shapes public health policy in the US. In the latter case, there has been increasing pressure at the political level to create policy that allows business interests to externalize any costs that might interfere with the flow of capital through the global economy. This has included allowing businesses and states to renege on historic obligations to provide stable pension benefits and adequate health care. This means that the ritual elements of health promotion are, then, employed to address issues that are at once individual and institutional, that attempt to address specific individual responsibilities and desires, while still attempting to find compromises within various systems of institutional regulation (Crawford, 2000). The ritual elements of health promotion are individual in that they are a means for situating individual experience in relation to the experience of others, defining limits for citizenship through the language of “choice”. They are institutional in

that they provide a means to disseminate and rehearse repertoires for sense-making about widely shared conflicts or dilemmas in a consumer society.

Health promotion discourses and the rituals that deliver them include subject positions that are relational categories which obtain their meaning in a particular situation in relation to other possible subject positions in the discourse (Törrönen, 2001). Individuals identifying with the subject positions within conventional health promotions discourses, then, take a stand against other competing positions, using the discourse to manage ambivalences between governance and the ethics of self or between discipline and self-care. Following Foucault (Törrönen, 2001), increases in knowledge gained through enactment of the mainstream ritual activities may be useful at a practical level, but also subordinate the user to the discourses' expectations concerning what is normal, permissible, and serviceable. In a case where so much is made of the participatory nature of cancer coalition rituals, it appears reasonable to explore to what degree these normal, permissible, and serviceable expectations actually closes off opportunity for emancipatory dialogue in the face of governance and disciplinary ambivalence.

Our "prevailing social attitude" is thus contradictory. Many of the changes that have occurred across public health policy, as well as more generally in relation to welfare policy, have lead both to deep cuts in service provision, while there continues to be expanding investments in the policing and surveillance of populations, particularly the poor. These changes have been part of the re-definition of "freedom" and civic engagement by neoliberalism and market fundamentalism (King, 2008; Duggan, 2003). Cornwall (2004) emphasizes that the language of empowerment in relation to participatory development is an inherently spatialized term, describing processes that in principle help "marginalized" or oppressed people move from a "periphery" to a "center" of some kind. For health promotion professionals, "empowerment" originated as a solution at the community level to remedy authoritarianism in healthcare (Beattie, 1991). It sought a "fix" for institutional rigidities that gave medical practitioners too much power to control the doctor-patient dyad, but it implied potential to reshape larger organizational networks into more democratic structures, thus becoming an impetus for institutional change. Neoliberal social forms, on the other hand, maintain existing social forms, by turning to a narrow, instrumental definition of professional encounters as well

as understanding public participation within a “harmony model” of power. In the case of healthcare, the trend has been to make professional encounters a matter of healthcare “consumption” so that each encounter is a discrete economic transaction. The redefinition shifts the impetus from mutual understanding between service providers and patients to an emphasis on who will pay for the expert knowledge and skills. Community participation is often focused on developing and sustaining interorganizational ties among relevant professionals in a community in hopes of identifying issues that make access to healthcare difficult.

Health promotion rituals, as a means for situating individual experience in relation to the experience of others” align with notions of “participation” and “empowerment” as spatializing terms (Cornwall, 2004). Both terms are entry points for discussing the “health disparities” as a kind of “euphemistic ambiguity” arises when the relationships are colonized by System imperatives. Euphemisms are innocuous words or expressions that replace other words found to be offensive or that suggest something unpleasant. They mystify offensive meanings behind a cloak of respectability or professionalism. In particular this case, “health disparities” distances the inequality inherent in current healthcare provision from the social structures and politics that creates that inequality, while “participation” and “empowerment” help sustain the broader “health disparities” language by suggesting that communities have a motive for active involvement in resolving access problems at the local level through coalitional politics.

Sampson (1990) warns against policy interventions that simply add-on a participatory component in hopes they will provide a motive for active involvement without making it possible for the marginalized to challenge identity constitutive standards of evaluation. I want to explore how this may be the case with cancer prevention coalitions in Appalachian communities what I will later terms as “invented traditions” that organize “Ladies Days” and other, small scale cancer prevention promotions. Seen in the larger context of “empowering” consumer choice, coalition participation becomes the continuation of trends to reduce democratic action to the ability to “vote” with one’s pocketbook, as opposed to bottom-up activism that strives to give voice to local health concerns and creates healthcare choices from the ground up.

The second factor traditionally shaping public health policy in the US involves the

medical concepts that predominate at a given point in time (Duffy, 1992). The historic era of transition politically and economically to neoliberalism has included an increasing focus on individual responsibility and personal, as opposed to collective, management of risk, both of which are redefining individual behavior, morality and identity. Public health policies generally, and cancer prevention policy specifically, have been strongly influenced by medicine's transition from what Klawiter (2008) calls the "regime of medicalization" to a "regime of biomedicalization". The regime change has included significant dismantling of post-WWII welfare services that included Medicaid financing, as well as the dissolution of much of the worker compensation and workplace protection policies that were once supported by a now diminished organized labor force. It has also included the rise of managed care, privatization, and the corporate rationalization of healthcare systems, as well as significant rolling back of environmental protections to curb exposures to carcinogens in one's home and community. Within the healthcare industry itself, the regime of biomedicalization has included profound investments in highly technological forms of treatment for many diseases. As far as cancer prevention, biomedicalization has signaled a transition away from efforts to identify "danger signs" of cancer in already symptomatic women or men with the accompanying reliance on invasive surgical interventions like the radical mastectomy, to population level surveillance of both symptomatic and asymptomatic populations, i. e., toward a focus on prevention through lifestyle intervention and a general shifting of responsibility for health and well-being away from the state to the individual (Klawiter, 2008).

Third, and finally, US health care policy has been shaped by the role of government in a country's economy changes (Duffy, 1992). The neoliberal turn has profoundly impacted healthcare. One contradiction of capitalism has played out in health through policies that have at once attempted to reduce public funding for healthcare while also allowing corporatization and privatization of healthcare services. Typically, according to Duffy, as capitalism develops production in a particular economic sector, it becomes increasingly "socialized" in the sense that there are efforts to create ties among sector participants such that resources can flow efficiently and transactions can be facilitated without impediment. Productive activities become more cooperative in character even as society's productive wealth is concentrated in the hands of a smaller and smaller number of

capitalists. Since the 1950s, the United States has made continual investments developing its biomedical research and industrial sectors. The 1970s brought a focus on cancer prevention and control, with screening becoming a gateway to further techno-biomedical treatment regimes. Regulatory changes also opened the healthcare system to privatization and corporate rationalization (Pollitt, 1982) even as environmental policy has been stripped of its teeth in relation to exposures to carcinogens (Rushefsky, 1986; Klawiter, 2008).

At the same time that the healthcare system has been changing nationally, Eastern Kentucky continues to be the site of significant social unrest around mining. The current battle over mountain top removal is a continuation of political struggles to stop the devastation of forms of surface mining that began in the 1950s. This struggle is part of a continuing response to larger trends in the coal industry to automate production, to reduce labor costs, to subvert and divide union support among miners, and to undercut contract agreements that supported regional health care for miners and their families.

Patel and Rushefsky (2005) add a fourth factor impacting the nature of health policy: *Which party is in power and what ideological commitments they are willing and/or able to enact at any given point of time.* They argue that how confidently government exercise authority and uses its regulatory power to protect the public health is a matter of which political party is in power at a particular period in US history. The external political environment, including whether or not there is the “political will” among leaders and coalitions to support broad policies to address health disparities, impacts whether research on health disparities makes much difference for affected populations (Gamble and Stone, 2006). The other factor affecting the ability of research to lead to meaningful legislation involves how issues are framed and incorporated into larger political agendas. As evidenced by efforts to reform healthcare, the Clinton and Obama administrations at the national level, and the Jones administration in the early 1990s in Kentucky, Democratic political leaders have been much more willing than Republicans to tackle healthcare disparities with policy solutions. The hegemonic explanations for no longer addressing these issues have been based in class politics that claim there exists a popular mandate for austerity policies in relation to social programming, that government’s role in health care has been too big, that further worker protections and environmental

regulations will stifle business growth, and that market interventions into the health care sector are in the long run better able to reduce costs and increase efficiency (Navarro, 1993).

We need to see factors three and four as intertwined because of the deep commitments the U. S. has made to neoliberal economic policies. Although community participation has become a buzzword within development circles, it is necessary to make a distinction between those spaces that are created locally and serve as sites where local groups come to voice their concerns and those spaces where local persons are invited to participate by commenting on policy (Cornwall, 2004). Early examples of community involvement in health care in the region serve as example of the power of local voices to make their desire for adequate healthcare heard. Other examples include the UMWA-financed Appalachian Regional Hospital System (Krajcinovic, 1997), ALCOR's summer youth projects that carried out local health assessments and screenings in southeastern Kentucky (Eller, 2008; Bailey, 2009), and the creation of the Mud Creek Community Health Clinic in 1969 (Cuoto, 1975). A number of other local health clinics followed in 1970 and 1971. By the early 1990s, when the Central Highlands Leadership Initiative on Cancer was enacted through the Markey Cancer Center at the University of Kentucky, significant efforts to include a participatory component in health care development had become the norm. And it is with this new effort at mobilizing participation that we can see the shift from a social democratic, bottom-up notion of community participation that accompanied the UMWA and community health movements to one that fits a revised neoliberal participatory framework which is predicated on a harmony model of power and focuses on screening and fund raising as primary modes of "empowerment" (Stokke & Mohan, 2001).

From New Social Movements to Communication Infrastructures

When I first conceptualized a research project about regional cancer prevention coalitions, I expected to encounter examples of what Habermas (1987) has called New Social Movements (NSMs). Because of the reputation of the southeastern counties of Kentucky for community-based political action, I fully expected to see grassroots efforts to address community health problems related to cancer based on the relationship between Appalachian identity and concerns about quality of life in the region. NSMs are

assumed to emphasize social changes in identity, lifestyle and culture (Picardo, 1997). They tend to avoid single issue campaigns and focus instead on change at a national or even global level. One of the first things I was warned about as I began discussing how to enter the field via contacts associated with my research assistantship at the Markey Cancer Center was that cancer coalition groups were typically single issue groups, mainly focused on promoting increases in cancer screenings among populations which had otherwise have avoided preventive services.

Another flag that I might be dealing with something other than an NSM came early in an interview with Gil Freidell, considered by many in the region to be the “father” of cancer prevention activity in eastern Kentucky. Dr. Freidell told me that efforts by the Appalachian Leadership Initiative on Cancer (ALIC), had failed completely (Freidell, 2009). ALIC was one of the first National Cancer Institute (NCI) funded projects to establish local cancer prevention coalitions and was begun in 1993 in order to develop and maintain volunteer coalitions in eastern Kentucky. He felt ALIC had 'proved' conclusively that genuine grassroots groups were not going to have enough continued interest in cancer prevention to last without incentives. A second NCI funded project, the Appalachian Cancer Network (ACN), decided to develop a corps of paid regional coordinators to work with local groups, as well as to give stipends to local county health departments to create coalitions based in the health department clinics. This finding made me think that coalitions were more like pressure groups that have formal organizations and “members”, instead of the informal, loosely organized social networks of 'supporters' that make genuine NSMs.

Buechler (1999) has argued that there is no single new social movement theory, but a set of new social movement theories, each a variant on general approach to "something called new social movements". I was initially attracted to using ideas from Habermas' Theory of Communicative Action (Habermas, 1983; 1987; Scrambler & Kelleher, 2006) because I was interested in how cancer prevention coalitions in eastern Kentucky, billed as “grassroots” groups by the Kentucky Cancer Program (KCP), might use strategies of participatory democracy to address cancer health disparities in the region. I spent the first several months of the project interviewing regional activists and health administrators about difficulties focusing on prevention in Appalachian counties.

But I repeatedly ran into skepticism about the efficacy of preventive intervention from medical practitioners in the region. This induced me to question my assumption that I was looking for a New Social Movement. The likelihood of getting a minimum of care for chronic conditions had become challenging for many Appalachians. High rates of chronic disease, poverty, and uninsured or under-insured persons in the population made it unlikely that local people would value the abstract goals of cancer prevention. Several physicians I talked to suggested that getting involved with screenings often led people into ever-expanding referrals for more costly testing while “false positive” results often led to unnecessary invasive and painful treatments. I attended several rallies and meetings in Lexington, Kentucky with groups involved in promoting health care reform. Once again I ran into ambiguity about the place of preventive health care in the current politics of health care. Although many people I talked to initially appeared to see cancer prevention and other prevention services as valuable, others appeared to feel there were too many forces impinging on their efforts to stay well. For many of them, the nation's food systems, the easy access to addictive substances and activities, and the growing moral ambiguity about whether healthcare is a right or a privilege overshadowed concerns about prevention. To make prevention genuinely possible, they appeared to be telling me, would require major overhauls of a deeply consumerist society.

It was around this time that an administrator with the Appalachian Regional Healthcare (ARH) System told me about Atul Gawande's (2009) story in the New Yorker magazine about the “cost conundrum” of health care services. Gawande, a surgeon, had traveled to McAllen, TX to investigate one of the most expensive healthcare markets in the US. In this small Texas town, Medicaid was spending three thousand dollars per enrollee more than the average per capita income of a resident of the same community. The article detailed the range of cost issues that has been making healthcare costs spiral out of control across the country. The ARH administrator told me that the only thing that had kept Hazard, KY from being the small town in the story was that Kentucky's Medicaid reimbursement rate was just low enough to allow McAllen to edge Hazard out in total costs. He complained that the over-utilization of services like dialysis and breast cancer screening were central to driving up costs in rural communities. There were not simply “barriers” to healthcare access in the region leading to severe “health disparities”, but a

chaotic, failed market for services being driven by what was affordable given local payer sources rather than some collectively understood consensus of how to define health and well-being.

This period of advanced preparation was intended to help me, as a novice health researcher, stake some kind of claim on the issue of cancer prevention. To be blunt about it, at this time I found cancer prevention to be boring. It appeared to be a collection of mundane health promotion activities that had become so institutionalized that it had become depoliticized, a perfect example of the kind of bureaucratic “technological fix” that Habermas (1987) said has come to define as rationalized instrumental action in modern society. But it was this 'boring' quality that led me away from thinking about New Social Movements toward an understanding of communication infrastructures (Star, 1999; Ball-Rokeach, Kim, & Matei, 2001).

Star (1999) has called the study of infrastructures in information systems the “study of boring things”. Infrastructure is both relational and ecological, and thus can mean different things to different groups. It is part of the balance of action, tools, and the built environment. Infrastructure is also frequently experienced as mundane to the point of boredom, involving things such as plugs, standards, and bureaucratic forms. Some of the difficulties of studying infrastructure involve how to scale up from traditional ethnographic sites, how to manage large quantities of data such as those produced by transaction logs, and how to understand the interplay of online and offline behavior. To this list I would add that the researcher must tease apart the “dialectic of discourse” that constitutes and is constituted by the interplay of actors, social practices, various social objects, and discursive representations (Fairclough, 2003).

The main resource that I began to draw from this literature was the willingness to dig for the historic narratives that had been associated with the formation of the now taken-for-granted infrastructure. Since infrastructure is typically invisible unless there is a breakdown or disruption in its functioning, looking for historic conflicts should involve uncovering local narratives about the kinds of issues that arise when people try to use the prevention system. The public health literature reductionistically calls such stories “barriers” to access. Star's work, however, suggests that the mundane practices and artifacts of health promotion rituals could also bear fruit as crucibles of stories. These

insights lead me to expand my sense of how conflicting stories might circulate in communities and at regional levels.

I began reconceptualizing cancer prevention activity as a communication infrastructure, a part of local “storytelling neighborhoods” embedded in a “communication action context” (Ball-Rokeach, Kim & Matei, 2001; Kim & Ball-Rokeach, 2006). Story telling neighborhoods are discourse networks used by local actors to discuss and define what it means to belong in that community. Network activity is understood to occur in a community context, a “communication action context”, made up of a variety of resources including healthcare resources, work conditions for local workers, the degree of ethnic diversity in the community, and other elements that impact the livability of the community and the health of its population. To what degree these networks facilitate community belonging, collective efficacy and civic involvement of concern here. In this study, I assume that any effort to “fix” the meaning of “community member” and make belonging a static description is futile (Mouffe, 1995; Törrönen, 2001). Being a community member and the feelings of belonging to a community do not arise from the necessities of biology nor do they emerge spontaneously as part of one’s position in the community social structure. Instead, belonging is discursively evolved from partial and momentary identifications when the subject positions are articulated in connection with each other by the internal logic of discourse that successfully appeals to common experiences (Törrönen, 2001).

In turn, cancer prevention coalitions are typically single issue organizations. In Appalachian eastern Kentucky paid coordinators are needed to sustain community involvement, and coalitions are situated as part of local public health clinics. This led me to rethink coalitions not as part of a broader New Social Movement, but as a kind of infrastructure project to carry information into and out of the region. From this new perspective, narratives about “barriers” to access to healthcare, the over-utilization of prevention services, and skepticism about the efficacy and cost effectiveness of preventive interventions are stories that circulate in local and regional “storytelling neighborhoods” of cancer prevention, shaping ways people feel about “belonging” in a community and positioning them as to whether or not they have the “right” to healthcare access as a preventive measure, let alone as a source of treatment. The experience of

boundary ambiguity associated with threats to one's status as a member of the community is a private manifestation of Neoliberal public policy solutions to the free rider problem that call for ever greater personal responsibility.

Recollection Two

As mentioned earlier, this second recollection introduces the notion that “invented traditions” (Hobsbawm & Ranger, 1983). Invented traditions emerge in novel situations, take on the form of historic practice, but actually express power differences in a community, many times shaping local identities in deep ways. My second recollection was triggered more recently during a visit to see a childhood friend who still resides in the WV county where we both grew up. While there, the two of us fell into conversation about people we used to know. My friend lives on the eastern end of the county, though we both grew up in communities on the western end of the county. His job as a public defender requires him to travel around the county and he often runs into people we both knew when he travels back to the west end. Since our youth, the economic conditions in the western part of the county have been in decline, widening a historic gap in community wealth that was already significant even forty years ago when we were teens. My friend said that he had met several people from the west end that now work on the east end, but who choose to continue to reside in the western communities. Recently he had a conversation with a mutual acquaintance who works for a bank on the east end, while still living in the west end. When asked if he would eventually move east, he snarled at my friend and said that he had no interest in moving, that he hated being in the eastern part of the county. He then articulated a range of familiar local resentments that had been prevalent in the western part of the county since we were kids – resentments that were class-based.

West Enders had always been Other to the more economically prosperous East. We were socialized into this as youths through sports rivalries and negative subject positions that appeared in local politics, particularly in terms of competition for economic development dollars. The fact that the county seat was in the eastern part of the county assured a higher number of professionals were located at that end of the county. The western part of the county had been the site of most of the coal mining done in the county and historically has produced hardwood timber since the 1890s. Environmental

degradation from these extractive industries have left scars in its hollows and along local streams. The presence of a historic resort hotel and access to state parks and national forest preserved an economic advantage based on tourism for the east end of the county as mining and timber cutting declined in the West.

Much of the local resentment has played out through the “invented traditions” (Hobsbawm & Ranger, 1983) that became part of inter-county rivalries around sports. The county consolidated its high schools in the early 1970s. Since the county is one of the territorially largest in the state, many kids from the more rural reaches of the county rode school buses for 45 minutes or more twice a day. The east end high school was nearly twice as large as the west end school when they were founded and has grown three times as large since. This size difference gave the school significant advantages fielding sports teams, but class differences were also expressed in how property taxes made more funding available for programs and other resources in the east end. The higher percentage of professional and merchant jobs on the east end also led to greater economic diversity in local economies at the community level. Over the years, the resort hotel, tourist industries, and growing service economy made it easier for the east end to adapt to changes as the economy globalized under the neoliberal policies of the past forty years. When the state decided to route an interstate highway so that it by-passed much of the western county, it sealed the economic differences that have been growing over the previous one hundred years.

What is important for me about this incident is the way it illustrates how “invented traditions” come to symbolically express power and shape local identities in deep ways. Hobsbawm & Ranger (1983) defined invented traditions as "both 'traditions' actually invented, constructed and formally instituted and those emerging in a less easily traceable manner with a brief and dateable period - a matter of a few years perhaps - and establishing themselves with great rapidity." These "invented traditions" are normally governed by overtly or tacitly accepted rules of a ritual or symbolic nature, and inculcate certain values and norms of behavior by repetition, automatically implying continuity with the past (Hobsbawm & Ranger, 1983). Invented traditions are initiated to address novel situations and take the form of other historic practices. They typically establish their past through quasi-obligatory repetition. The history of socialization through sports

performances, band competitions, and other activities designed to build “school spirit” have become sites for fund-raising to supplement school budgets. These activities display the physical, social, and artistic accomplishments of local children and thus became matters of community pride. As those traditions were colonized by efforts to raise funds (and as schools became more dependent on these fund-raising activities), the economic differences among communities became undeniably apparent, making class-based differences apparent as well.

The invented traditions around sports grounded the emotional life of youth in my county in the class-based divisions that have been part of the division of labor in the county since early timber barons began to cut and mill local hardwoods for national distribution. As the West has declined economically, a fairly stable white “underclass” has emerged in the communities on that end of the county. My friend estimates that about 80% of his caseload as a public defender now comes from that portion of the county. The aesthetic appeal of the housing and building stock on the West End has all but disappeared as the turn-of-the 20th-century buildings built by the railroads and the timber industry have fallen into disrepair or been torn down altogether. What remains of this heritage is only a remnant, hidden in the origins of street names, geographic locations, and communities.

The seasonal nature of high school sports schedules links the identity process to specific time frames across a year. Gender, race, ethnicity, and sexual orientation come to be intertwined with class through such activities, including many ways through which broad distinctions like participates/does not participate, wins/loses, succeeds/fails, follows the rules/cheats, and cooperates/does not cooperate. Identity markers intersect as the rules of inclusion/exclusion and performance evaluation shape and are shaped by interaction over time. These rules come to define the social settings (Carspecken, 1994) in which community members participate in activities. They structure hierarchies of participation, and establish the shared understandings that set boundaries between groups. Typically, these rules are largely not directly observable. They only become explicit when someone or something disrupts the normal flow of daily activity which maintains the hierarchies of participation.

Seasonal activities also have a spatial element. Schools become social sites where

youth involved in sports or band spend time training, practicing, and performing (Carspecken, 1994). Such, activities become delimited both geographically and temporally, allowing coordination with other schools to stage the sporting events, band concerts, and other activities. Parents become involved as boosters, concessions are sold, funds are raised for school programs, uniforms, sports equipment, band instruments, and transportation to and from events. The cultural and social activities taking place in areas around a school come to include the spatialized and temporalized rules and routines that can be termed “locales” (Carspecken, 1994). They are examples of “regionalized social action” (Giddens, 1984) because the routines found in one social site are influenced by, and themselves influence, routines in other nearby sites. Settings in these various sites become typified and can be explained by “modes of regionalization which channel, and are channeled by, the time-space paths that members of a community or society follow in their day to day activities. Such paths are strongly influenced by, and also reproduce, basic institutional parameters of the social systems in which they are implicated” (Giddens, 1984, p. 142-143).

I am claiming that the combination of invented traditions, social sites, and social settings coordinated in a locale is at the heart of this study of cancer prevention coalitions. I hope these concepts will show how public health activities related to cancer prevention become part of the local culture in Eastern Kentucky and how these “region-building institutions” construct a version of regional identity. I am using regional identity as defined by Paasi (2003):

‘Regional identity’ is, in a way, an interpretation of the process through which a region becomes institutionalized, a process consisting of the production of territorial boundaries, symbolism and institutions. This process concomitantly gives rise to, and is conditioned by, the discourses/practices/rituals that draw on boundaries, symbols and institutional practices. While practice and discourse are the media by which the structural and experiential dimensions of the process are brought together, it is useful to distinguish analytically between the identity of a region and the regional identity (or regional consciousness) of the people living in it or outside of it. The former points to those features of nature, culture and people that are used in the discourses and classifications of science, politics, cultural activism, regional marketing, governance and political or religious regionalization to distinguish one region from others. These classifications are always acts of power performed in order to delimit, name and symbolize space and groups of people. Regional consciousness points to the multiscale identification of people with those institutional practices, discourses and symbolisms that are expressive

of the structures of expectations' that become institutionalized as parts of the process that we call a 'region' (Paasi, 2003).

The importance of this notion for Appalachian Studies cannot be over-emphasized. It has been the ongoing mission of many in Appalachian Studies to confront and deconstruct historic efforts to construct invented traditions that represent Appalachian culture as somehow timeless, unique, isolated and ahistorical (Pudup, Billings, & Waller, 1995; Becker, 1998). It is my contention that Appalachian culture has always been configured in relation to the forces of Modernity as these circulate throughout in the larger national culture. Snapshots of different eras in Appalachian history capture the current partial successes of the national culture to try to fit the region into the national image. Typically, Appalachia has been positioned as Other in the national consciousness and used to define what we as a nation do not want to be. This Othering historically reflects the nation's prevailing attitudes toward its industrial labor force, its energy resources, the environment, and the worthy and unworthy poor. Class, race, ethnicity, gender, age, and sexual orientation all intersect within this prevailing attitude and are endlessly configured and reconfigured.

Recently, Appalachian lifestyles have been framed in national media discussions of health care and disease prevention as locked in a struggle to reconcile discipline with self-care. We have seen Appalachians show up in media as "pillbillies" addicted to Oxycontin and other prescription drugs, as addicted to moonshine, moon shining, driving too fast, tobacco, over eating, Mountain Dew, scratch-off lottery tickets, crystal meth, marijuana, domestic violence, four-wheeling, and a "sedentary lifestyle". Using the ethnic heritage of a few ancestral Scotch-Irish Appalachians to explain the variety of cultural traits and lifestyle choices in the region assumes a biological connection to an equally degraded cultural group from an imagined pure ethnic past. The tenuous connection between the Scotch-Irish and other "Celtic" coal miners builds a specious argument for an essentialized, genetic basis for both Appalachia's stereotypical connection to the division of US labor in the US as well as its "pathological" subculture. Arguments of this kind have surfaced and resurfaced in conservative political circles as a means to marginalize some populations deemed unworthy of help. The private struggles of the marginalized are held up as examples of a pathway to exploitation of public goods,

the impetus for free riders on the dole. Poor and uninsured Appalachians thus become a “throwaway” population that demonstrates its economic and cultural obsolescence through failures of self-regulation and high rates of chronic disease (Watkins, 1993). But the use of such cultural explanations to legitimate perceptions of Appalachian difference should actually and only serve as a cue that power relations are at work.

It is not any a priori cultural difference that makes ethnicity. “The Chinese laundryman does not learn his trade in China; there are no laundries in China” This the Chinese immigrant Lee Chew asserts in Hamilton Holt's *Life Stories of Undistinguished Americans* (1906). One can hardly explain the prevalence of Chinese-American laundries by going back to Chinese history proper. It is always the specificity of power relations at a given historical moment and in a particular place that triggers off a strategy of pseudo-historical explanation that camouflage the inventive act itself (Sollars, 1988, p. xvi).

We cannot explain the presence of coal miners or “pillbillies” by going back to the Celtic roots of a segment of the central Appalachian population anymore than we can understand the presence of Chinese laundries by studying pre-modern China. We can, however, track historic “discoveries” and “rediscoveries” of Appalachia as a “world apart” and question the relations of power that are shaping prevailing political, social and economic attitudes in a given era. Public health intervention has been shaping the nature of Appalachian health in eastern Kentucky through philanthropy at least since A. D. MacCormack secured Rockefeller Sanitation Commission funds in 1911 to address hookworm, Federal intervention has been present at least since 1932 when MacCormack was able to use his political influence to get relief funds from the Roosevelt Administration for health care among the indigent (Jackson, 1962). Public intervention has been shaping the form of regional health infrastructure since that time.

From the perspective I am building here, cancer prevention activities represent a discursive practice through which “features of nature, culture and people ... are used in the discourses and classifications of science, politics, cultural activism, regional marketing, governance and political or religious regionalization to distinguish one region from others” (Paasi, 2003). I will attempt to show that cancer prevention activities are involved in creating a particular version of identity for Central Appalachia. As such these activities circulate alongside two other discourses currently being used to define Appalachian identity: the discourse of mountaintop removal and the discourse of

prescription drug addiction. Each of these discourses have emerged in parallel to the construction of communication infrastructures that claim to be based in “grassroots”, bottom-up community movements concerned about local problems, yet are structured as technocratic, top-down conduits to facilitate the movement of professional opinion, expert knowledge, and funding support from state and national organizations to community agencies. The resulting interorganizational networks elicit occasional comment from communities, but are largely focused on maintaining ties among local professionals and the agencies they represent.

Chapter Three: Roll the Stone – Cancer Prevention as Ritual

Cancer Prevention Rituals in the Neoliberal Service Economy

If I judge a thing is true, I must preserve it. If I attempt to solve a problem, at least I must not by that very solution conjure away one of the terms of the problem. For me the sole datum is the absurd. The first and, after all, the only condition of my inquiry is to preserve the very thing that crushes me, consequently to respect what I consider essential in it. I have just defined it as a confrontation and unceasing struggle (Camus, 1955, p. 23).

In *The Myth of Sisyphus*, Camus (1955) wrestled with the futility of man's search for meaning in face of the cruel unintelligibility of the modern world. He argued that facing the absurdity of such a world offers us three choices: suicide or some other form of escape like addiction, a turn to spirituality and religion, or acceptance of and continual rebellion against absurdity by continuing to try to create meaning in life. Many of the survivor stories include descriptions about how confrontation with one's mortality leads those diagnosed with cancer to select the second of Camus' choices. Personal stories about those struggling to respond to a cancer diagnosis often include mention of the survivor's church commitments as well as their gratitude for God's grace. At a broader social level, though, the massive effort to prevent cancer can be understood as a collective choice to accept and rebel against the experience of absurdity in the face of cancer.

Yet, narcissistic fantasies have also become part and parcel of the mediation of the illness experience in this cultural environment as we regularly view or read tabloid stories about miraculous recoveries, heroic patients and medical professionals, powerful technologies used for healing (Seale, 2002). We are encouraged to see opportunities for growth in every setback, rather than to question whether the setback is the result of a rigged game. The rhetoric of mainstream cancer medicine has evolved into a highly heteronormative, individualized, apolitical, and ahistorical discourse (King, 2006; Klawiter, 2008), but also, like other mainstream mediated images of cancer in mass culture, it operates as a medium for ritual enactments intended to deal with basic existential concerns at an emotional level (Seale, 2002). The symbolic calls to a "War on Cancer" and other dramatic slogans, as well as heroic media representations of medical professionals, are standardized mythic stories that attempt to calm collective anxieties in

modern consumer societies that arise as people confront the fact that no amount of money or technology guarantees they can avoid the eventuality of death (Langer, 1998; Seale, 2002).

Recent psychoanalytic discussions of the links between individual subjectivities and the social environment conceptualize our current predicament as linked to a return to unregulated capitalism. The goals of an unfettered market economy are in conflict with the goals of a democratic society (Peltz, 2005). In the “new economy”, innovation and increased ease of consumption are held up as the strengths of the system. Yet these are also the mechanisms which impact financial security, frenzied pace of work, and ever widening gaps in income and wealth. Within a Neoliberal worldview this frenetic activity is summarized (and possibly trivialized) as “lifestyle” and consumption choices are thought to be a better expression of one’s values than voting (Quelch, 2008). The middle class is understood as coping with the loss of a just vision of the future, based on “good enough” social provision and containment. As social safety nets are weakened and dissolved, consumption is idealized to fill the absence of a consistent ideal of social provision (Peltz, 2005).

In this environment, psychological defenses that deny and distort the awareness that one is not omnipotent may prevail, rather than allowing one to consider dependence on others. Defensive postures come into play when one denigrates and denies helplessness and dependence while controlling and idealizing the objects of dependence, mainly through the idealization of consumption and frenzied levels of work and purchasing. For Peltz (2005), the decision to allow the “new economy” to remain unregulated, with market needs dictating the direction of social policies, is a demonstration of a lack of commitment to social values and priorities aimed at guaranteeing all members of society “inalienable” democratic rights, particularly the provision of social needs. The consensus-building strategies of cancer prevention coalitions must be understood as operating within this predicament.

The notion of ontological security is relevant here. Ontological security, according to Anthony Giddens:

...refers to the confidence that most human beings have in the continuity of their self-identity and in the constancy of the surrounding social and material environments of action. A sense of the reliability of persons and things, so central

to notions of trust, is basic to feelings of ontological security; hence the two are psychologically related. Ontological security has to do with 'being', or, in the terms of phenomenology, 'being-in-the-world'. But it is an emotional, rather than cognitive phenomenon, and is rooted in the unconscious (Giddens, 1990, p. 92)

From this perspective, the health promotions of cancer medicine operate in a similar symbolic space as highly mediated and conventionalized institutionalized rituals that attempt to restore and maintain ontological security for those of us left behind after our loved ones have passed from cancer even as they operate materially as part of a biomedical industrial complex for the early detection and treatment of cancer (Giddens, 1984; Seale, 2002). Ontological security is an active engagement with others that requires a bodily co-presence, as well as communication, face-to-face interaction, and the use of language. It is important in the constitution of practical consciousness based on the everyday routines of the Lifeworld (Giddens, 1989).

If we watch much television we can see that "peak experiences" through acts of consumption have become common place, at least in media representations of the "good life" (Bauman, 1998). The consumption of biomedical services for cancer prevention and treatment are promoted with many of the same techniques and make similar promises. As I was gathering data for this project, I read many stories in local newspapers from the sixteen case study counties about people who were diagnosed with cancer, followed through on preventive and treatment recommendations, and survived after treatment for a period of time. In several instances, I also discovered obituaries for the same survivors in later editions of the paper. The experience of finding these obituaries always had the same disheartening effect, regardless of whether the person was a child, teenager, young adult or adult. I would feel disappointed, largely because the announced completion of treatment had raised expectations that survival is not only possible, but likely. Survival is supposed to make the survivor a better person for endured the treatment ordeal and I found it disheartening that death denied the individual the benefits of his or her sacrifice.

Such heavily mediated messaging offers us "transitional objects" that allow us not only to search for and find needed information in a time of disruption, but also soothes our existential anxieties in the face of disorder and confusion (Silverstone, 1994; Seale, 2002). I found over time the repetition of the promises of transcendence left me angry

and cynical about the failure of biomedicine to live up to its transformative promise. Klawiter (2008) points out that at a symbolic level, “survivor” has become a universalizing category, its associated symbol of the pink ribbon left free-floating and ungrounded, while the notion of “medically underserved” women is used to discursively disembled “medically marginalized” populations from context and community. Survivors are typically singled out and given a special status in the rituals and discourses of cancer prevention, while those who succumbed to cancer, as well as the “medically underserved” were left ill-defined, with little criteria offered to understand who the people in these categories typically are.

It is in this symbolic space that I have aimed much of my critique of cancer prevention. The actual processes of everyday cancer medicine have, for me, a sisyphusian quality to them. Many of the professionals and coalition members I have encountered in the course of this project have been doing the work of cancer early detection and prevention for a number of years, putting one foot in front of the other, always striving to patch together resources in support of disadvantaged patients. This part of their efforts I find quite admirable, and in most cases, I believe that many medical service providers involved with cancer early detection and prevention are sincerely trying to bring needed services to a region that has historically been ignored as the modern biomedical industrial complex has mushroomed into the behemoth it has become. Yet, their efforts are often restricted to merely trying to raise awareness of cancer itself and their mandate, no matter how gussied up with claims of being “grassroots” and “participatory,” is aimed at avoiding disturbing the community status quo or possibly challenging any contributors to cancer rates beyond individual lifestyle.

From Rituals to Institutions

The important element I want to focus on in this paper, overlooked in many studies of cancer-related health promotion, is not the numbers of persons recruited to for screening, the numbers of pamphlets given out, nor is it the number of persons who attend educational events. It is also not the measure of increased “awareness” of cancer a particular person achieves thanks to promotional activities. My focus, instead, is how promotions like Ladies Day, along with seasonal activities like Relay for Life and Breast Cancer Awareness Month, ritualize a vision of selfhood based on a conception of the

rational medical consumer whose performative impetus is to embrace and embody redemption through biomedical ordeal. Such redemption makes survivors worthy of the “freedom of choice” available to the American consumer-citizen. Local cancer coalition activity serves as an infrastructure to assure resources are available to maintain at least the presence of this vision in the local community. These rituals also perpetuate a mythic narrative that helps audiences make sense of the disordering and disruptive impacts that cancer has on the lives of community members by defining communities at risk, victims, the heroic actors charged with fighting those risks, and the standards by which resolution of those risks must be defined (Langer, 1990; Seale, 2002). This chapter focuses mainly on the social infrastructure of cancer prevention while later chapters will take up its ideological and mythological dimensions.

Materially, examination of the political economy of cancer medicine would lead one to acknowledge that the “transformative miracles” are in fact technological commodities for sale in a rapidly growing economic sector that now amounts to sixteen percent of the US economy by some estimates (Squires, 2011). The expansion of the market for cancer-related services has seen its greatest growth as women from the baby-boom generation have become the targets of marketing efforts by the medical community. Mammography and pap smears, as reliable procedures for screening for breast and cervical cancer, have in turn lead to both policy and marketing emphasis on these forms of cancer, often to the exclusion of other sites for cancer. The population of non-symptomatic women, now constructed as “risky subjects” (Klawiter, 2008), have become part of a massive effort to redefine otherwise healthy populations as “at risk”. Breast cancer, because of the early development of a reliable screening methodology, has become the central condition in the race to open up a market for cancer medicine:

The marketing of breast cancer is associated with the consumption of information, medicine, technology, social support, events, food, paraphernalia... The audience of breast cancer survivors, women at risk, and supporters is the most highly valued product in the political economy of breast cancer, and corporations within and beyond the breast cancer industry pay large sums of money for access... the packaging of breast cancer in terms of pink femininity, the broader cancer culture, and the history of the breast cancer movement has solidified cancers’ social status and cultural accessibility. Breast cancer is indeed the darling of corporations – but it also has the power of celebrity, symbolism, myth, and the attention of mass media (Sulik, 2011, p. 112).

"Health" has emerged as a symbolic medium through which one confirms one's fitness to be identified as a member of the middle class (Crawford, 1984; 2000; Backett, 1992). Lifestyle in this era of consumer capitalism are no longer simply based on shared ways of life embedded in structural positions and tied to one's place in a production sector. Lifestyle has become "a bond that connects individuals in very complex, extensive, and intermediated networks of consequences" (Sulkenen, 2009, p. 4). Wasteful, corrupt, or self-destructive activities by some members of a community, "negative health behaviors" like smoking, poor eating habits, or the use of addictive drugs, put strains on support networks that are part of community safety nets. At the individual level, they are intended to be used protectively to open up a transitional space that insulates the individual from criticism and pain as they restructure and clarify their lifestyle priorities (Layton, 2000). At the societal level, identity categories like "survivor", or "in recovery," have become deeply racialized and gendered, deployed by communal power hierarchies to mark self-destructive activities, segregate those who have lost control of negative health behaviors, and allow those persons to bond again with the status quo provided they submit to various treatment regimes. Claiming to be "in recovery" or claiming "survivor" status marks passing through the liminal phase of the recovery ritual cycle to a new point of equilibrium, with new, healthier, lifestyle behaviors now in place.

In the new service economy, many employers want to see employment-based insurance plans disappear altogether as they transition to "flexible" service sector employment. The rhetoric of "health disparity" operates in this symbolic space as a euphemistic trope that uses "class-as-lifestyle" discourse (Watkins, 1993; Jarosz & Lawson, 2002) to obscure politically sensitive issues like efforts by employers to externalize healthcare costs associated with employment-based insurance plans. "Class-as-lifestyle" is a discursive strategy that reflects the ways that the transition to a Neoliberal service economy has destabilized traditional class-based identities related to production and shifted the emphasis to the "mobile, performative individual agency" of the consumer (Watkins, 1993, p. 48).

Another politically sensitive issue masked by the "class-as-lifestyle" myth and the euphemism "health disparity" involves the ways various interest groups in the healthcare

sector seek to increase profit taking through strategic deployment of market-based solutions in healthcare financing. As this practice has increased, care for indigent and underserved are increasingly seen as “externalities” which must be shifted to public funding streams. Both efforts to forsake employer-based health care for many of the new “flexible” service jobs and efforts to externalize the costs of indigent care involving shifting risks that threaten the solvency of health care systems in an age where both for-profit and non-profit alike must be seen as efficient and accountable (Hammond, 2004).

These trends belie a paradox in regional economic development as the new economy’s job creation has tended towards more and more low-wage service jobs while well-paying jobs in mining and manufacturing become more scarce (Foster, 2003). Health-related coalitional politics at the community level has become a negotiation process about how to manage scarce safety net resources and hence distribute risks posed by those whose pleasures have particularly devastating consequences on individual as well as the public health. It must also distribute the consequences of risks taken in the name of economic development that increasingly fails to provide employment that assures much of the regional population adequate health insurance benefits. This last issue - the ways communities must absorb the externalized costs of regional economic development - is particularly important to understanding the consequences of choices by early detection and screening activists to render class-based identities absent from its discourse and, in particular, to ignore the impact of coal mining on the regions health. Each of these issues will be taken up in later chapters, particularly chapter seven, as I attempt to summarize the symbolic in terms of an evolving cosmology increasingly apparent in the region as neoliberal participation and coalitional politics become more prevalent.

Regionalization and Routinization as Ordering Principles

In Chapter One I referenced Hobsbawm & Ranger’s (1983) definition of invented traditions as "both 'traditions' actually invented, constructed and formally instituted and those emerging in a less easily traceable manner with a brief and dateable period - a matter of a few years perhaps - and establishing themselves with great rapidity." These "invented traditions" are normally governed by overtly or tacitly accepted rules of a ritual or symbolic nature that inculcate certain values and norms of behavior by repetition, automatically implying continuity with the past (Hobsbawm & Ranger, 1983). The

current rituals of mainstream cancer prevention began to appear nationally in the mid-1980s and were taken up in Kentucky in the early 1990s.

Prevention rituals are “regionalized social actions” (Giddens, 1984; Carspecken, 1994) that configure ethnic, gender, and familial identities, even as they appear to ignore class-based community differences among the populations they target. Social settings in the various enactment sites become typified by “modes of regionalization” which channel, and are channeled by, the time-space paths that members of a community or society follow in their day to day activities, with their paths strongly influenced by, and also reproductive of, basic institutional parameters of the social systems in which they are implicated (Giddens, 1984, p. 142-143). These “institutional parameters” include a powerful set of biomedical procedures for conducting cancer risk assessments using various forms of screening and various structural features of medical practice that assign roles for different medical professionals in the assessment process and which allocate technological resources for conducting the procedures. Among these biomedical procedures, too, are conventions that allow ready reconstruction of medical practice and allow for a shared perception of effectiveness across the medical social world (Becker, 1974; 1976). The interpretive framework for reading mammographic or Pap smear screenings can be standardized and taught to achieve some degree of consistency over time and across locations where screenings are done, making the medical social world the central reference group by which effectiveness is measured, rather than community standards of health and well-being.

Standardization can become problematic, however, if it leads greater distribution of knowledge controlled by powerful subgroups of actors in the social world. An example is the way that the Kentucky Women’s Cancer Screening Program relaxes professional boundaries so that screening interpretations can be made by nurse practitioners as well as physicians. This adaptation allows rural public health clinics in resource scarce locales to do screenings without necessarily having to have the more expensive services of a physician on staff. It also allows the same clinics to receive Medicaid payment for screening services, a revenue stream previously controlled by family physicians. Although this adaptation gives an advantage to public health clinics, many doctors feel this adaptation infringes on their domain of expertise and encourages patients to seek

inferior services in the face of a potentially significant health risk.

Paradoxically, public health clinics may give screening services away during specific seasons, typically spring and fall, as part of local health promotions, usually called “Ladies Day”, but also at local health fairs, community fairs, and celebrations. Ladies Day activities that include free cancer screenings occur at most of the public health clinics I visited: In the spring, during a time frame coordinated with the American Cancer Society’s Relay for Life events, and in the fall during October, the month known as Breast Cancer Awareness Month. It is important to acknowledge that local providers typically do not have the resources or the expertise to develop patient education materials and they rely on education pamphlets and other materials provided by the National Institutes of Health, the National Cancer Institute, and Centers for Disease Control, and American Cancer Society. Such standardization and routinization of cancer prevention activities and educational discourse articulate local health providers to a larger system of cancer prevention organizations and institutions, aligning local activities with state and national public health priorities in large part through the adoption of the conventions of medical procedures, marketing, and administration.

The institutionalization of biomedical intervention in cancer has been underway for some time in the Appalachian region, yet these efforts were initiated (and have continued) under changing social, political, and economic conditions. What began in many instance as a grassroots exercise in social democratic participatory action to define health and well-being in local terms and to build locally-responsive healthcare organizations has been redefined as a neoliberal system of choices in which local “health consumers” are expected to exercise their rationalized “freedom” in the healthcare marketplace. Invented traditions, social sites, and social settings are coordinated to form a “locale” with unique sets of person-situation interactions. Giddens’ (1984) definition of “locale”, as “the use of space to provide the settings of interaction, the settings of interaction being essential to specifying its contextuality” explains the ways health promotion rituals offer order to the local social world in the face of changing social, political, and economic conditions. Health promotions confront the disordering effects of illness and disease, hence attempt to deal with “matter out of place” (Douglas, 1978; Crawford, 2000) by offering explanations of risk, and prescribe behavior change strategies that “provide a template for

our larger predicament” (Crawford, 2000, p. 221). This predicament results the contradictions of modern capitalism as it is being restructured in a neoliberal form and the use of health promotion rituals provide standardized responses for dealing with struggles to exercise discipline and maintain self-care practices.

Coalition members, who in the case of all but one of the twelve cancer prevention coalitions in the sixteen counties, are predominately professionals from healthcare and related fields, are also framed within the rhetoric of current coalitional politics as “grassroots” members of the community. Though most coalition members live and work in the counties where they participate in cancer prevention activities, their interests and professional alignments also resonate with those of the larger medical community and they are subject to the professional ethics and constraints not only of their professions, but of the organizations for which they are employed. They rely on these organizations for their livelihood, and at best operate as insiders who are also agents of change. The infrastructure building they engage in is committed to the larger existing system of care and they do not seek solutions outside recognized “best practices” in biomedicine. That is, they do not strive to deploy local knowledge to generate local solutions. In my mind, calling most of these groups “grassroots” redefines the nature of participation, misrepresents professional “market-building” as a process of community-based organizing, and displaces the basis of coalition involvement from the lifeworlds of local communities in the region to the institutions and systems of professional affiliation of the professionals who maintain the coalitions. Community mobilization as practiced in eastern Kentucky appears to fit the neoliberal definition of participation rather than a social democratic one (Mohan & Stokke, 2000). It is fundamentally a “top-down” strategy for institutional reform in which federal and state agencies, private industry, and collaborating non-governmental organizations are encouraged to engage in efforts to make institutions more efficient by removing “barriers” to cancer prevention services. Empowering the powerless is to be achieved within the existing social order and without any significant negative effects upon the power of the powerful. In the case of the sixteen counties in this study, this includes the coal industry and the local businesses and citizenry who benefit from it.

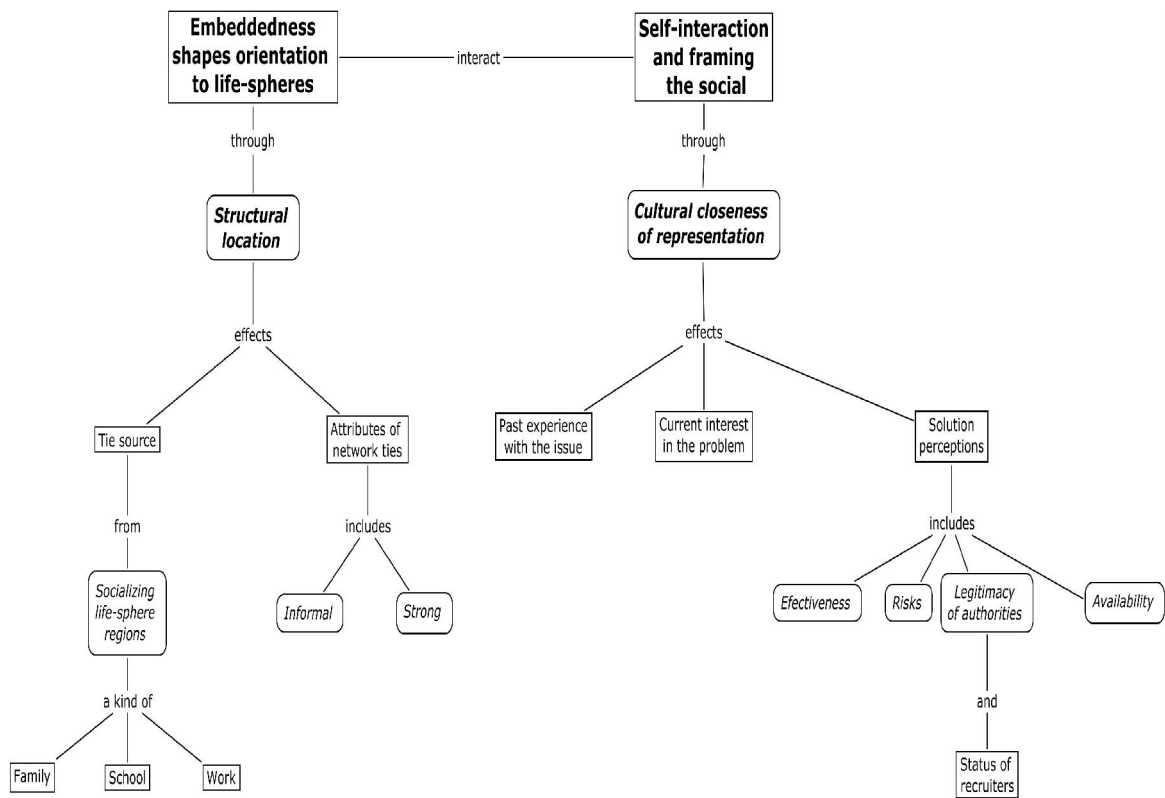
Passy and Giugni (2000) offer a phenomenological perspective that looks at the

constant work of definition and redefinition of the social world by participants in collective action. This perspective also includes examination of the self-positioning actors deploy throughout their experiences with the social world as a means to make sense of interactions and activities. The authors stress the joint impact of the actors' structural location and their individual life histories on political commitment. Sustained participation is understood as a direct result of the stabilization of commitment and depends on the interplay of deepening involvement when their embeddedness in social networks and their changing perceptions of such embeddedness in relation to their life-spheres. This perspective puts the meaning of participation at the center of their social world as the knot that ties social networks to shared cultural representations. I will review Passy and Giugni's (2000; 2001) theoretical perspective as a starting place to identify aspects of the current meaning of participation as I observed it in eastern Kentucky, particularly the ways this participation contributes to routinization and regionalization as early detection and screening activism become institutionalized. I will further discuss the ways their work guided my ethnographic observation and interviewing and describe one of the coalition networks I encountered to illustrate its application. In doing so, I will describe the configuration of that coalition as a site of regionalized social interaction that is redefining regional identity. At the end of the chapter I will explore the "sensitizing concepts" Giddens (1984) uses to define "regionalization" and link these sensitizing concepts to the coalition activities in the Tri-County Coalition to demonstrate how the networks and meanings embedded in them are ordering the spatial as well as symbolic realms and providing a basis for a new regional identity.

Network Embeddedness, Self-Interaction, and Commitment in Social Movements

In two articles, Passy and Giugni (2000; 2001) outline their phenomenological approach to understanding the relationship between individual commitment to collective action and social networks. The perspective is summarized in **Figure 1: The Passy and Giugni Theory**. In this approach, actors are said to be embedded in the various "regions" of activity and meaning associated with family, school, work, and other areas of the Lifeworld. The authors call these regions "life-spheres", but I will maintain the convention of calling them "regions." This is in many ways consistent with the idea of regionalized social action mentioned above, but also does not confuse the idea of multiple

Figure 1: The Passy and Giugni Theory



“life-spheres” with the Habermasian (1983; 1987) term “Lifeworld,” which I will also use frequently throughout the project. Network interaction across regions typifies everyday perceptions through the repetition, with family, work, and school being primary regions (or reference groups in Shibutani’s (1955) terminology involved with socializing actors. Frequency of activation of a given region forms and reforms a hierarchy of preferences for meanings in different regions over time, serving as a source of perspectives used to define situations and evaluate their meaning and consequences. The embeddedness in these networks shapes orientation to the Lifeworld by shaping the value of different regions.

Involvement in social movement activity expressed as network interactions in different regions of the actor’s Lifeworld can either lead to greater interrelationship between regions, and thus increase commitment to a movement, or it can decrease over time in a given area of experience and effectively lead to a disarticulation of the region from the rest of a person’s Lifeworld. In the case of involvement with social movement

activity, this diminished activity can result in an actor leaving or dropping out of movement activity. Informal, interpersonal ties grounded in the socializing regions of the Lifeworld provide the kinds of linkages that draw an actor into movement involvement, with strong ties to recruiters most likely to be formed among members of preferred regions of activity and meaning.

The second part of the Passy and Giugni theory includes a discussion of how actors shape their embeddedness in movement networks through self-reflection, a process the authors call “self-interaction”. The more the meanings shared by a particular region of actors is culturally similar to the ideological frames of a given social movement, the more the region can act as a context of recruitment for a movement and transmit the contextual understanding to recreate the social settings required in community mobilization. These shared, similar meanings are transmitted to individuals as part of being socialized into the various related regions. Perceptions of the social problem and the potential effectiveness of solutions favored by a movement, the risks involved with exercising the solution, and the legitimacy of authorities are part of the stories individual tell themselves and others as they reflect on involvement with the movement. Past history with the issues related to a movement, one’s present personal availability for participation, and one’s changing definitions of the situation affect the individual’s perceptions of participation effectiveness, the legitimacy of authorities, as well as assessments of continued personal availability. As actors interact with recruiters and other members of a movement, they share resources, obligations, and responsibilities, as well as the joys and sorrows of commitment. In doing so, they strengthen relationships within and between regions of the Lifeworld, thus deepening their embeddedness in social movement networks. The structural position an actor occupies in this crosscutting set of ties becomes the object of the self-reflection process and comes to be integrated in the frames of reference of the committed actor.

Adapting Passy and Giugni’s (2000; 2001) perspective to explore cancer prevention coalitions must take into consideration unique features of how mainstream cancer early detection and screening activism is interpenetrated by state and federal agencies, private industry, philanthropic organizations, and cancer activists. Klawiter (2008) has suggested that the “culture of action” around mainstream early detection and screening activism

challenges two major sociological assumptions about social movements. First, social movement scholars typically expect to find clear boundaries to movement activities, with easily distinguished differences existing between state, private industry, philanthropic organizations. Mainstream early detection and screening activism is an extension of the breast cancer awareness campaigns of the 1970s and 1980s and promotes “awareness” of the importance of constant vigilance, annual mammograms, and early detection of cancer in order to “protect” women from dying of the disease. This particular form of participation emerged in the 1990s, tying the interpenetration of the state, private industry, and breast cancer screening advocacy to mass-participation fund-raising events, as well as providing a means to respond to political pressures to expand mammographic screening to medically marginalized communities. The resulting “community mobilization” has become a favored target of corporate cause-marketing campaigns and public-private partnerships that target state-funded screening programs on the local level. As a result, it is often unclear where one organization ends and one begins, particularly since coalitions in eastern Kentucky were primarily made up of organizational actors.

The second assumption challenged by mainstream early detection and screening activism is that social movements engage in contentious forms of social action (Klawiter, 2008). Early detection and screening advocacy constructs compliance with screening guidelines as a moral responsibility of individual women. This responsibility implies a subtext of civic duty to participate in the various fund-raising events as well as a subtext of family obligation. Together, these texts and subtexts are part of a discourse of solidarity in which the only enemies are a lack of awareness and various financial, cultural, and physical barriers to screening. The “bad guys” here are cancer, a lack of awareness of its dangers, and the euphemized notion of “barriers” to getting screening. This discursive construction is important because it depoliticizes participation, even as the state is solicited for funding and support. It distracts from asking questions about who the “medically marginalized” are or how they became that way. These questions are reserved for professionals, either researchers sampling populations, or clinicians defining eligibility for public assistance.

This discursive construction also circumvents questions about how and why many of the marginalized populations who are the focus of intervention come to carry such a great

“cancer burden” that they would require special attention in the first place. Put another way, the discourse expresses a clear preference that makes present the valorization of racial, ethnic, and familial identities embedded as citizen-consumers who express their “freedom of choice” within a market for health services while leaving absent any expression of class-based identities embedded as citizen-workers who have been excluded from access by discriminatory “victimization” that might also imply a universal “right” to (Figure 2).

Figure 2: Discursive Presence/Absence in Early Detection and Screening Advocacy Discourse

	Identities	Mode of Participation
Present	Racial, ethnic, and familial identities as universalized as “survivors”	“Freedom of choice” by the consumer-citizen in the medical marketplace
Absent	Class-based identities universalized as “worker”	“Right” to healthcare granted worker-citizen as a result of discriminatory exclusion from care

Similar discursive constructions are typical of neoliberalism in that it deploys identity categories to mobilize attachments to collective identities that are marked by a denial or disavowal of vulnerability (Layton, 2009). By avoiding attachments to class-based identities, local power hierarchies are left unquestioned, sustaining the status quo. For the most part, participation can be done at a distance such that knowledge of the social conditions and social needs of the “medically marginalized” are rendered abstract (Rodger, 2003). Sympathy becomes an intellectual experience rather than an empathic, emotional one. Any knowledge of social need is gained derived through a behaviorist perspective rather than a structural one. This post-emotional tendency (Layton, 2009; Mestrovic, 1997; 1998; Rodger, 2000; 2003) is encouraged through the inward, familial view of social need promoted by early detection and screening activism marketing messages.

I addressed the issue of social movement boundaries and network embeddedness identified by Passy and Giugni (2000; 2001) by initially limiting elicitation of the cancer coalition population to the local actors and organizations who self-identify as cancer prevention coalition members. In doing so, I was able to map local participation networks

specific to cancer prevention without having to completely trace all the different ties to state agencies, private industries, or philanthropic organizations. Only those persons, and the organizational entities they represent, who claim membership in the local coalitions were identified, establishing network descriptions whose boundaries are based on participation as a member of the coalition. This participation embeds the actor in a larger medical social world and involves socialization over time into the discourses and conventions of mainstream cancer prevention. For most of the persons I identified as coalition members, this included school and work experience related to biomedicine. Many persons in the coalitions had experiences with cancer in their family history, mostly through family members whom had contracted the disease, although some had actually been diagnosed themselves and had gone through the recovery process.

The meanings that actors in the cancer coalitions make and reflect on reinforce the consensual spirit of participation to assure that promoting constant vigilance, annual mammograms, and early detection of cancer will remain in the foreground. This stance also serves to leave undisturbed the potential for fund-raising through partnerships with corporate and business interests. I would argue also that accepting these consensual messages also leads to a kind of ideological hegemony that silences any effort link regional issues such as the impact of mining on the extensiveness of the cancer burden in the region. When asked about mining's impact on the regional cancer burden, most of the people I talked to were well aware that espousing this construction of cancer risk would jeopardize fund-raising activities and diminish turnout for promotional events.

Local coalitions have been encouraged to establish themselves as 501C (3) entities in order to maximize the coalitions' ability to pursue fund-raising activities. Even though the Kentucky Women's Cancer Screening Program allows Medicaid funding to be utilized to address the needs of medically marginalized community members, such funding does not include stipends for travel or meals, cannot be used to provide a room for a loved one who accompanies a patient out of town for services, or make up for wages lost when patients and their families must take time off from work to pursue medical services. Fund-raising to help defer these costs is the incentive for local coalitions to become 501C(3) organizations, making it even less likely that coalitions will confront the production of toxic products or environmental destruction by corporate industries. Since

local health departments must interact with local health boards and the county judge executives for their budgets, confronting local sources of employment like the mining industry would put public health in direct conflict with powerful economic interests in the community. Combined with the construction of women as in need of “protection” by medical professionals, and obligated to themselves, their communities, and to their families to focus on maintaining an optimistic awareness of the need for screening and vigilance, proximity to the hazards of mountaintop removal mining and other forms of environmental pollution are left out of the conversation about cancer and its prevention as it takes place in local coalitions. The “brightsiding” (Ehrenreich, 2009) optimism of mainstream cancer prevention thus operates as a repressive force that silences much of the conversation that would be necessary to confront actual region sources of health disparity in the first place.

The Tri-County Cancer Coalition

As a way of introducing the Tri-County Coalition, let me first review a few methodological concerns, particularly social network data collection and analysis as it was deployed in conjunction with participant observation and informal interviews. When I first conceived the plan for this project, as I have said before, I was expecting to encounter New Social Movement activities in the various communities I was interested in researching. I had four main interests: 1) how identity themes emerge in coalitions as participants forge Lifeworld-based commitments to cancer prevention (Passy & Giugni, 2000, 2001; Passy, 2002); 2) how those identities, as part of the “regional building institution” (Paasi, 2003) of public health and the regionalization of social action (Giddens, 1984), might be linked to Appalachian identity; 3) what differences might exist structurally between different groups that are “coalitional” as opposed to organizational or movement oriented (Diani & Bison, 2004; Scrambler & Kelleher, 2006); and 4) what kinds of conversational resources, particularly media discourses, participants drew upon to develop and sustain their identification with cancer prevention activity (Gamson, 1992; Scrambler & Kelleher, 2006). The first two of these interests are the focus of this chapter. The third interest is the concern of the next two chapters, and the fourth interest is the focus of the last three chapters.

The Tri-County Coalition was one of two 501C (3) entities and they had linked goal

setting to fund raising within the yearly seasonal cycles of cancer prevention activities. This added additional responsibilities to coalition routines because it made the coalition accountable to donors as to how money was used. This extra accountability in turn entered into the reflexive monitoring of funds and the assessment of who was entitled to receive them, affecting the levels of basic trust that could be achieved between those in need and the coalition.

I used Passy and Giugni's (2000; 2001) work to shape my early interviews and observations with coalitions in the sixteen counties. I was able to interview public health officials and/or coalition members from all sixteen counties as well as do participant observation in several different coalition meetings. I attended Ladies Day activities in Knott County and other promotional activities through the sixteen counties. I read and analyzed coalition newsletters and the annual newsletters published by the Kentucky Cancer Program (KCP). From these observations I was able to reconstruct the coalition social networks from the twelve counties that have coalitions.

The Tri-County Coalition is made up of health professionals and community members from three counties – Knox, Laurel, and Whitley Counties. The coalition merged efforts by the three different counties because Corbin, KY, the central town in the three counties, actually lies in part in each of the counties. Its central location makes it a convenient site for coalition meetings and other prevention activities. Promotional activities carried out around the three county areas by the coalition include Ladies Day promotions in the spring and fall to promote breast and cervical cancer screenings and participate in local health fairs and other community gatherings to distribute cancer prevention literature. Screening is conducted under the guidelines of the Kentucky Women's Cancer Screening Program, establishing a strict timetable around which cancer screenings carried out. Central actors in the coalition are also Tobacco Control Specialists, so there is also promotion of the Cooper/Clayton Smoking Cessation programs conducted at each of the county health departments. Along with these basic cancer prevention promotional activities, the Tri-County Coalition is one of two coalitions that engage in fund-raising as a supplement to the CAP goals based in the Kentucky Women's Cancer Screening Program.

As one of two coalitions that had established itself as a 501C(3) entity, the Tri-County

Coalition is also the only multiple county coalition, making it the best choice to describe the extent to which coalitions organize promotions rituals and cancer prevention fund-raising as regionalized social interaction. As mentioned in the first chapter, all the counties in this study produce coal, and Laurel, Knox, and Whitley Counties, the counties represented by the Tri- Coalition, are no exception. They are situated on the western boundary of Appalachian Kentucky, but, as mapping the layout of coalition sites will show, they are located within close proximity to the damage being done by mountaintop removal mining in the region, making it difficult to explain silence concerning the extent of public health risk related to cancer that this form of mining. In the following sections I will discuss one of these coalitions to illustrate how coalitions engage in regionalized social action, configuring the meanings of cancer prevention rituals spatially, socially, and symbolically.

Historical Background

Historically, cancer screening activity has emerged as part of a larger public health policy regime change that has been in transition since the 1970s as the country has moved away from the New Deal/Cold War political consensus and into a neoliberal/neoconservative consensus. This transition has had impacts on the development and maintenance of the healthcare social world generally and has shaped the types of intersections and segmentations within that world that have created current local cancer prevention subworlds. David Armstrong (1993) argue that health-related identity spaces have opened up and widened by successive regime changes in public health since the 19th century into a kind of political “no man’s land” where danger is discovered anywhere and everywhere and we can no longer rely solely on sovereign powers to monitor threats. We are all being folded into a web of surveillance mechanisms that is rendering our subjectivities as a sort of “political awareness” of self that is constantly at work policing the body and its relationship to the external world.

Klawiter (2008) puts the promotion of technology and skill at the center of modern breast cancer health promotions, illustrating how promotion of breast self-exams, clinical breast exams and mammographic screening became the means by which cancer prevention activities were extended beyond symptomatic populations to asymptomatic populations of women. The transition from an era of medicalization as the dominant form

of medical institutional activity to the “regime of biomedicalization” (Klawiter, 2008) began in the 1970s when cancer prevention specialists began to see screening technologies as central to prevention and control activities. The shift in perspective transformed the medical gaze from a narrow preoccupation with “dangerous” women exhibiting signs and symptoms of cancer to global surveillance of “risky” populations of women, many of whom are not and will never develop cancer, but must now bear the burden and obligation of self-surveillance.

Community-based cancer prevention has followed have a particular template first developed in the late 1970s as part of the Breast Cancer Detection Demonstration Project (BCDDP) which evolved into a methodology to address cancer health disparities via a series of “leadership initiatives” that invited participation by a number of minority populations beginning in the mid-1980s (Klawiter, 2008). BCDDP provided a template for building cancer prevention networks, and the template has been re-applied in Appalachia first through the Appalachian Leadership Initiative on Cancer (ALIC) in 1992, of which the Central Highlands Leadership Initiative on Cancer (CHALIC) was the project carried out in eastern Kentucky. ALIC brought together researchers from the University of Kentucky, Pennsylvania State University, and West Virginia University. According to Gilbert Freidell, MD, the CHALIC program director at the University of Kentucky (UK) at the time, one of the primary goals of the program was to tap local community members for participation in a community-based interest group or coalition of volunteers to function as a self-directed link to the cancer prevention programs at UK (Freidell, 2009). Over time, according to Dr. Freidell, it was expected that the volunteer groups would form, engage in some limited set of promotional or educational activities, then disengage from further involvement. The CHALIC project was unable to demonstrate that an all-volunteer, “grassroots” effort could be sustained over time that drew only on local cancer survivors, interested citizens, health activists, and related health organizations. Dr. Freidell stated in the interview that it was, thus, decided to appoint paid coordinators at the Kentucky Cancer Program to act as organizers and liaisons with communities and to make small grants to local public health clinics to encourage them to utilize staff to form and maintain coalitions from within the community.

Successive NCI-funded projects followed, including the Appalachian Cancer Network Project (ACN) and the Appalachian Community Cancer Network (ACCN) Project. Both originated as part of NCI's Special Populations Network Programs, which funded similar projects in seventeen other regions around the country with the mission of addressing cancer burden among medically underserved populations around the US. Congress passed the Breast and Cervical Mortality Prevention Act of 1990 authorizing the Centers for Disease Control and Prevention (CDC) to provide critical breast and cervical cancer screening services to underserved women, including older women, women with low incomes and racial and ethnic minority women.

In 1990, the Kentucky Senate passed Senate Bill 41 (SB 41), establishing a breast cancer screening programs throughout the Kentucky Department for Public Health. SB 41 established a Breast Cancer Advisory Committee for the purpose of advising the Commissioner of the Department for Public Health on developing guidelines for breast cancer screening services. It also established general guidelines for the operation of a breast cancer screening program to be located in each county health department clinic. By 1994, the General Assembly made amendments to the original statute through the passage of House Bill 931. The bill clarified statute language, added three new members to the Breast Cancer Advisory Committee, and expanded reporting requirements to the Governor and Legislature. The General Assembly again amended existing law in 1998, designating the first of November as the due date for the annual report on the Breast Cancer Screening Program. The 1998 amendments also added a radiologist to the Advisory Committee.

The resulting breast cancer screening program, the Kentucky Women's Cancer Screening Program, serves as a template for most cancer screening activity done with the clinics I visited. Public health clinics are able to access Medicaid funding to aid uninsured and other low income populations in receiving breast cancer screening. Recent legislative efforts spearheaded by the Kentucky Cancer Consortium (KCC). The Kentucky Cancer Action Plan (CAP) is the comprehensive cancer control plan to reduce our burden of cancer in Kentucky. KCC is the organization responsible for implementing the CAP. As a blueprint for cancer prevention action, the plan addresses four key areas of the cancer continuum: prevention, early detection, treatment and care, and quality of life.

Each section contains major goals, objectives, and suggested strategies. The Kentucky Cancer Program, the Kentucky Department for Public Health, and the American Cancer Society developed the plan in 1999 with funding from the Centers for Disease Control and Prevention. The first Kentucky Cancer Action Plan was completed in 2001. The Plan's most recent revision was approved by the Consortium in 2005.

KCC cooperates with the Kentucky Cancer Registry and the Kentucky Cancer Program (KCP) as a means to implement the CAP agenda. The Kentucky Cancer Registry operates as the primary data collection agency monitoring the cancer burden across the state. KCP was established in 1982 and is jointly administered by the University of Kentucky Lucille Parker Markey Cancer Center and the University of Louisville James Graham Brown Cancer Center. KCP is a state-funded and university-affiliated, with sites in Lexington and Louisville. It also promotes itself community-based, based on its support of the community cancer coalitions that have been established around the state. It operates through a network of 13 regional offices staffed by professional cancer control specialists who provide local leadership on cancer prevention and control initiatives for all of Kentucky's 120 counties. The KCP works closely with the Kentucky Cancer Registry and 15 District Cancer Councils across the state to identify and develop interventions/solutions to address cancer problems in their communities.

In 1990, federal, and state agencies were legislatively empowered to structure a system for delivering breast cancer screening services for low-income women who do not have health insurance. This was done first through passage of the National Breast and Cervical Cancer Mortality Prevention Act of 1990 (Klawiter, 2008). This legislation led to the first Breast and Cervical Cancer Control Program (BCCCP) in California. By 1993, the Breast Cancer Act of 1993 was passed and a more expansive system of services was implemented. This second wave of program development was broader in scope and deployed the idea of "community mobilization", which embraced the idea of developing not only the number of sites and providers, but also targeted the community attitudes and health beliefs in an effort to expand the reach of early detection and prevention services into medically marginalized networks. The Appalachian Leadership Initiative on Cancer (ALIC) in 1993 was one of several similar projects around the country, with the Appalachian Cancer Network (ACN) and Appalachian Community Cancer Network

(ACCN) being followed programs that continued to develop the “community mobilization” approach in Kentucky.

Central to the strategy of mobilization and promotion of these programs encouraged has been the building of a community infrastructure for delivering the services and meanings of mainstream early detection and cancer screening activism. Through the networks of community organizations, social service organizations, advocacy groups, and private businesses, the circulation of educational materials and promotional messages intended to change the cultural attitudes of the community (Klawiter, 2008). The intention of this national project, then, was to create a state-financed, locally organized, interpenetrated social movement which targets cultural change in attitudes about cancer prevention, particularly in low-income, under-insured populations. This is mainly accomplished by through a range of promotional activities, the message of which was designed to link women’s racial, ethnic, and familial identities to participation in the practices of cancer screening. Early detection promotional messaging side-steps questions about class-based identity and the economic conditions which increase the potential cancer burden of some communities and not others, and produce conditions of medical marginalization and “health disparity” in favor of a discourse of familial duty and personal valued region of family, combined with self-reflection on fear of cancer and its consequences to one’s family and quality of life in the future (Klawiter, 2008; Sulik, 2011). Thus the discourse of cancer early detection and prevention creates a powerful message which targets self-interaction with themes of familial responsibility grounded in relationships between women family members. Civic duty is framed largely in terms of the ability to consume products which sponsor cancer research, though periodic involvement in mass fund-raising events like the American Cancer Society’s Relay for Life is encouraged as tribute to awareness-raising. By assuring that this message circulates frequently in local community networks, women have been more likely to encounter cancer prevention discourse and messages about the obligation to be screened.

As I mentioned earlier, I repeatedly ran into skepticism about the efficacy of preventive intervention during this early period of planning and initiating contacts. Many of the health professionals I talked to were concerned that the high rates of chronic disease, poverty, and uninsured or under-insured persons in the population suggested that

people's "taste of necessity" (Wacquant, 2006) made it unlikely local people would value the abstract goals of cancer prevention when the necessity of getting even a minimum of care for chronic conditions was so close³. Several physicians I talked to suggested that getting involved with screenings often led people into ever-expanding referrals for more costly testing and could result in false positive results that led to invasive and painful treatments. I attended several rallies and meetings of Lexington, KY groups involved in promoting health care reform, and again ran into similar ambiguity about the place of preventive health care in the current politics of health care. Though many people I talked to initially appeared to see cancer prevention and other prevention services as valuable, they also felt that the nation's corporate controlled food systems, easy access to addictive substances and activities, and growing moral ambiguity about healthcare as a right rather than privilege overshadowed concerns about prevention. To genuinely make prevention possible, they appeared to be telling me, would require major overhauls in a deeply consumerist society that appeared politically impossible at the time.

This period of advanced preparation was intended to help me, as a novice health researcher, stake some kind of claim on the issue of cancer prevention. Cancer prevention and control appeared to me to be a collection of mundane health promotion activities that had become so institutionalized that it had become depoliticized. It had lost its connection to its earlier feminist roots and become a perfect example of the kind of bureaucratic "technological fix" that Habermas (1987) said has come to define rationalized instrumental action in Modernity. Its 'boring' quality that led me let go of looking for a New Social Movements, and instead start exploring regional cancer coalitions as communication infrastructures (Star, 1999; Ball-Rokeach, Kim, & Matei, 2001). After about six months of preparation and IRB review, and another couple of months of background interviews, I was able to make contact with coalition members in a number of counties in southeastern Kentucky. I chose to focus on two particular sets of counties in large part because they had been the focus of several years of research by the Appalachian Community Cancer Network (ACCN) project at the University of

³ Wacquant (2006), following Bourdieu (1997), suggests that bourgeois tastes defines themselves by negating the "taste of necessity" of the working classes. Local working class and poor community members sense this rejection, see many middle class goals, such as those of cancer prevention, as "above" or outside their tastes, and, hence, do not strive for them as do there middle class neighbors.

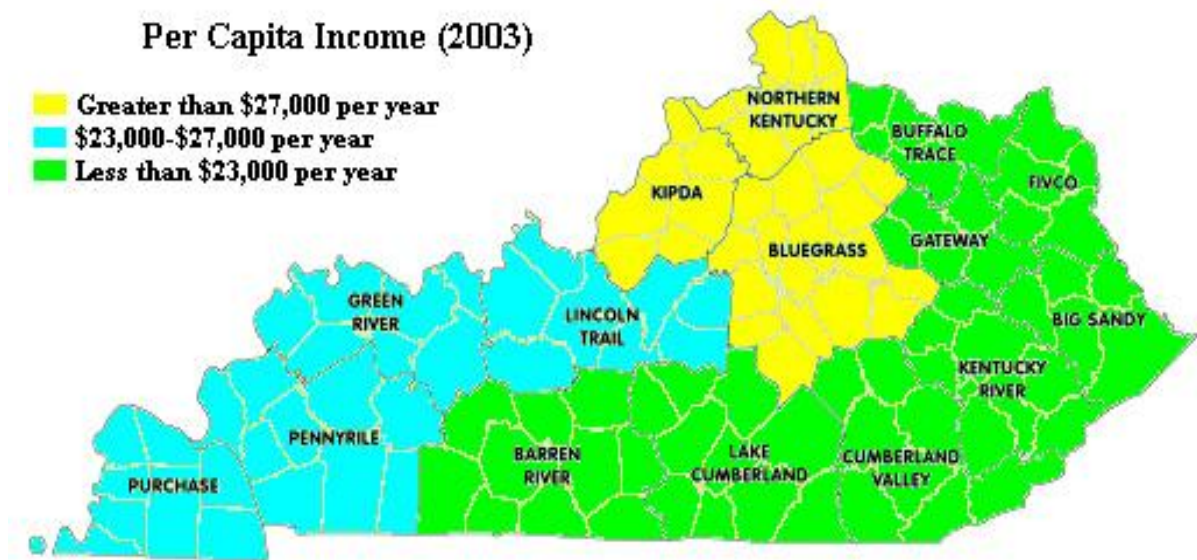
Kentucky's Markey Cancer Center. As the third incarnation of cancer prevention projects addressing cancer health disparities in southeastern Kentucky, ACCN had been focusing in recent years on developing health promotions related not only to breast and lung cancer, but also more recent projects related to cervical cancer and colorectal cancer. Much of this work had been done in the Cumberland Valley Health District and the Kentucky River Health District, a combined area encompassing sixteen counties in southeastern Kentucky. I began making contacts in the county health departments by asking to meet with whoever was handling cancer prevention activities.

The Cumberland Valley Health Department serves the counties of Bell, Clay, Harlan, Jackson, Knox, Laurel, Rockcastle, and Whitley in southeastern Kentucky and the Kentucky River Health Department serves Breathitt, Knott, Lee, Leslie, Letcher, Owsley, Perry and Wolfe Counties. Together, this sixteen county area became the site of the project. These health department districts are contiguous with the Cumberland Valley Area Development District (ADD) and the Kentucky River Area Development District. From the map pictured in **Figure 3: Area Development Districts in Kentucky by Per Capita Income**, it is easy to see that the two area development districts and their related health departments are located in some of the poorest counties in southeastern Kentucky. The narratives and discourses of Appalachian poverty that intersect with health disparity issues, as mentioned above, intersect with other discourses and narratives concerning the region's historic identity in terms addiction. I will reserve that discussion for the last chapter of the project. They also exhibit a curious gap in terms of the impacts of mining on the health of the region that is only recently being investigated in the face of the destructive impact of surface mining on the region. I will fill in some of this gap at the end of the chapter and will return again to the issue in chapters five and six.

Cancer Rates in the Sixteen Counties

Table 1: Cancer Rates by County, 1995 to 2007 details the cancer rates in the sixteen counties in terms of five measures. The measures include the overall invasive cancer rate for each county, and age adjusted rates for cervical cancer, female breast cancer, lung and bronchus cancer, and colorectal cancer. The rates are the average rates of each county in the given categories for the time period from 1995 to 2007. The first of these measures serves as a basis for ordering the table and is the overall rate of invasive

Figure 3: Area Development Districts in Kentucky by Per Capita Income



cancers. Owsley County, by far had the lowest overall rate of invasive cancer at 217.58 per 100,000, as well as the lowest rates in the other four categories, while Breathitt County had the highest rate of 640.56 per 100,000 (Kentucky Cancer Registry, 2009). Owsley County has the lowest cancer rate in the state, while Breathitt County has the highest.

Table 1: Cancer Rates by County, 1995 to 2007

Name	Invasive cancer rate	Age adj cervix uteri	Age adj female breast	Age adj lung and bronchus	Age adj colorectal
Owsley	217.58	8.53	67.45	46.18	29.99
Jackson	498.36	12.99	107.28	71.57	54.37
Clay	504.43	12.71	100.74	75.09	57.14
Whitley	509.43	12.53	121.77	90.94	60.06
Knott	515.28	11.94	96.36	80.7	52.91
Bell	518.3	16.82	112.47	75.37	61.88
Leslie	519.46	15.99	94.84	76.14	52.29
Knox	534.67	13.28	111.89	81.18	50.62
Laurel	536.3	13.74	118.19	69.18	56.25
Rockcastle	538.33	13.67	109.2	80.98	62.38
Letcher	542.92	10.29	105.66	92.57	72.28
Perry	544.61	11.7	107.9	97.72	59.22
Harlan	546.67	14.83	101.74	94.65	59.36
Lee	568.71	18.52	101	91.89	46.88
Wolfe	597.05	19.47	133.34	104.22	85.79
Breathitt	640.56	16.27	94.32	100.18	59.96

The choice of the four age adjusted categories had to do with the kinds of programming one sees in local public health clinics. Breast cancer prevention is typically the most promoted cancer program, with lung and bronchus cancer prevention linked to smoking cessation activities being a close second. In recent years the National Cancer Institute (NCI) has been instrumental in disseminating promotional materials and technical assistance in regards to cervical cancer and colorectal cancer. Both have seen improvements in the effectiveness of screening procedures for each disease in recent years. The development and distribution of a vaccine for the human papilloma virus (HPV) has been a focus of health promotion research as much for the political fallout that surrounded its release as conservative family groups voiced concerns that the drug might have a negative impact on sexual behavior among teen girls. In a later chapter I want to discuss more thoroughly the gendered nature of the types of cancers that get most of the emphasis in the cancer coalitions because it says a lot about the politics that have been guiding cancer prevention research funding. It also will begin to clarify some things about how national philanthropies like the American Cancer Society dominate the local cancer prevention arena and help establish the major temporal boundaries for the socio-emotional economy for cancer survivor sympathy.

Coalition Goal Setting

Observing goal setting in community cancer coalitions involved exploring two related pairs of questions: “Are there differences in terms of the locus of origin of activities? If so, what are those differences and how do they come about?”, and, “Do coalitions consider issues outside the hegemonic discourse of screening as valid considerations in goal setting? If not, how do they maintain coalition boundaries so as to depoliticize activities?” The answers to the two question sets involves understanding the historical development of cancer prevention activities in Kentucky, explication of the macro-structural features of current cancer prevention that embed cancer prevention in public health policy in Kentucky, and recognition of how these policy demands are translated at the local level.

In terms of whether there are differences in terms of the locus of origin of activities goal setting in coalitions is profoundly overdetermined at the federal and state level, and then constrained further at the local level by the location of coalitions in county public

health clinics within a seasonal cycle of fundraising structured by the American Cancer Society's Relay for Life program and National Breast Cancer Awareness Month, originally sponsored by the drug company Astrazeneca. Most of this translation occurs in the process of defining the organizational routines and practices of cancer prevention in local public health clinics, hospitals, and family practice clinics. In the coalitions located in public health clinics, the coalition meetings operate as a forum where different member organizations make one another aware of these practices and programs and how they are accessed. The coordinator from KCP may offer news of grant-funding availability or new practices being encouraged by NCI or the CDC. The local ACS representative may also discuss program availability as well. Information sharing and discuss appeared in many cases to be the main goal of monthly meetings. Scheduling of joint promotional events or the pursuit of advertisement for these events comes up periodically, in part to coordinate with season events like Relay for Life and Breast Cancer Awareness Month, but also to take advantage of local events like health fairs and community gatherings that might provide access to potential patients for screening services and prevention education. In this sense, the coalition is a kind of “clearinghouse” that makes members available to local organizations with presentations about cancer and its prevention.

As part of a much larger interorganizational system, the goals of coalitions I explored typically came about in one of two ways – generally in terms of whatever are the current goals of CAP and more specifically by the availability of local personnel to take them on a project and carry it out. Additionally, attempting to incorporate as a 501C (3) charity that engages in fund-raising expands the ambitions of the coalition and makes even greater demands on coalition members. Of the sixteen counties I visited, coalitions were operating in twelve counties and, ten of those coalitions set goals completely within the limits of CAP, organizing two to four “Ladies Day” activities to promote breast cancer screening and doing community education promotions at local health fairs and schools.

Two coalitions expanded their goal setting to incorporate fund-raising activities for the purposes of raising additional funds to cover the costs that patients encounter when they become involved in following up on cancer screening activities. Typically funds are raised through community activities like raffles, yard sales, and the solicitation of direct donations. The money raised is added to a transportation fund and used to purchase gift

cards or gas cards for people experiencing economic hardship who are unable otherwise to pay traveling expenses to a medical facility for follow-up on screenings or for further treatment. At every location I visited the issue of travel expense is the number one barrier experienced by low income patients during the screening and treatment process.

Interviews with the coalition Secretary reveal that the coalition raises several thousand dollars a year through fund-raising activities and grant writing. One promotional activity through which donations are both elicited and reinvested is the development of a flyer circulated in the Tri-County area that lists where one can eat out in a smoke-free environment in the three counties. The coalition is able to sell advertisement space in the flyer to local restaurants and other businesses, as well as provide a medium through which the coalition's presence in the county is made known. I observed the coalition over several months from summer into fall during which time they were engaged in raffling off a handmade quilt that had been donated to the coalition. Money collected through the raffle and other donations is used to purchase gift cards for use to pay travel expenses for cancer screening and/or treatment follow-up for persons otherwise unable to afford to pay themselves.

Probably the most heartbreaking element of the process is the concern that coalition members responsible for dispersing the gift cards have for the possibility that the cards will be misused to buy something inappropriate, such as cigarettes or beer. The concern appears to be about the misuse of the funds as well as the possibility that the community would see a recipient misusing its funds. Only a select number of persons, one from each health department, are able to disperse cards. The cards were applicable at only select gas stations and were specially designed to limited only to the purchase of gasoline.

To me this exemplifies a major difficulty with the discursive construction of prevention literature as a vocabulary of racial, ethnic, and familial motives. As mentioned above, neoliberalism deploys identity categories to mobilize attachments to collective to collective identities that are marked by denial or disavowal of vulnerability (Layton, 2001). In the case of early detection and cancer screening activism, this process is accomplished through the presence of messages mobilizing women based on ethnic, racial, and familial obligations, particularly in relation to overcoming barriers to screening. Funds are available for the cost of screening, but all other human needs –

transportation, food costs, time off from work (not to mention job protection if one's time away from work becomes extensive due to illness), and child care – are externalized. These are all material needs which low-income families struggle to cover day in and day out, much less persons who have been referred for screening.

Coalitions allow communities to avoid confronting who the “medically marginalized” are by assigning solutions to these basic needs to service providers. Coalition fund raising, done without the participation in coalitions by a sizeable number of community members beyond the medical profession, assures that the community need not confronted with vulnerable, needy, and imperfect patients. The discourse offers little or no guidance on setting boundaries under these circumstances beyond the professional judgment of coalition members. The vulnerability and dependence of these patients is acknowledged and judged in parallel with the standards described by the Kentucky Women's Cancer Screening Program. Only small amounts of aid provided, yet, the conditions of the aid is severely restricted to guarantee as much surveillance and accountability for the aid as possible. The issue becomes even more difficult if screening results in positive results that require more tests, travel, and costly services and aid over time. In the case of the Tri-County Coalition, patients can only access financial aid once a year because of high need and limited funds.

Seasonal shifts in public attention to cancer prevention follow corporate promotional routines related to the American Cancer Society's Relay for Life and Astrazeneca's Breast Cancer Awareness Month. Local cancer prevention professionals tend to piggyback promotional activities on the seasonal rituals that have developed in local communities in response to these corporate interventions. County public health clinics, the local hospitals, the two banks involved in the coalition and numerous other community organizations establish teams to participate in Relay for Life fund-raisers. This period in the spring and again in October, during National Breast Cancer Awareness Month, is when many local health fairs and community festivals are scheduled. It is also the time frame when public health clinics are most likely to hold Ladies Day health promotions to encourage cancer screenings. Other dates may be scheduled in accordance with the local county fair or if a particular business desires an in-service focused on women's health issues.

Composition

Questions about the composition of coalition membership include, “How does someone become involved in coalition activity? Once involved, do they move in and out of involvement with various mobilizations, or do they become involved and stay involved in a continuous manner?” My original plan was to investigate features of existing cancer coalition networks as they manifested long-term commitment by coalition participants. To do this I drew on the work of Passy and Giugni (2001), who describe the relationship between social network involvement and social movement participation in terms of two functions, a *socialization function* and a *structural location function*. The socialization function is the process by which a potential participant, through their embeddedness in community networks, comes to recognize an issue as significant to themselves and their community. For Passy and Giugni (2001), embeddedness originates the process of recruitment, locating recruitment in the Lifeworld of an actor as a potential for mobilization ready to be activated. It is the experiential basis for empowerment and part of the Lifeworld of that person. Many community members have local knowledge of how the issue fits with as well as disrupts the normative consensus in a local community; the authors state this in terms of the ways local embeddedness places a community member into interactive structures that allow her to define and redefine the framing of the social world. This function involves the way network embeddedness aids an individual in gaining political consciousness of issues and operates as the cultural role of networks. Socialization reflects the long-term engagement in community networks. For the most part, coalition members claimed status as Appalachians, were born and raised in the region, and lived in the communities where they worked. Still most of them did not claim to know each other growing up. Most of them did take part in local events and took part in other community mobilizations, such as local drug prevention coalitions. It is this current involvement in multiple community improvement activities that characterizes the basis of most coalitional socialization, serving as the vehicle for a shared knowledge of how coalitional politics take place and accomplishes things.

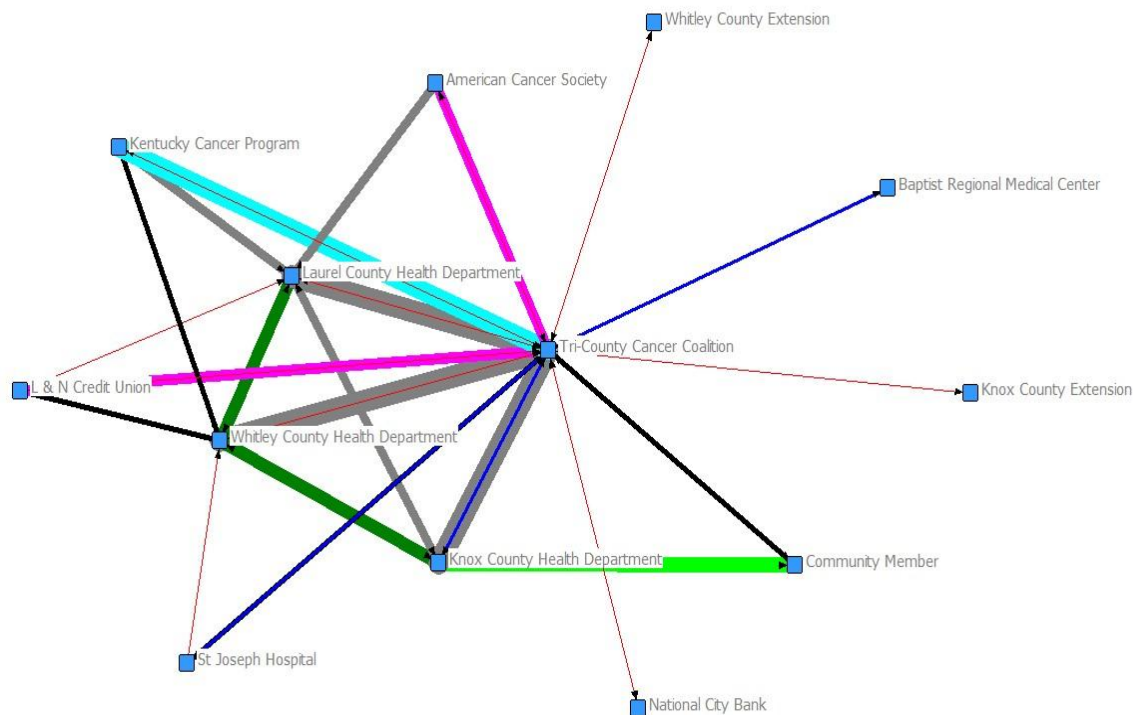
I would argue that it is likely that someone embedded in community networks in eastern Kentucky has at least some familiarity with media discourse about the region’s historically negative image in national media in terms of health-related, social,

environmental, and economic inequities (Gamson, 1992). For many folks in the age range that makes them eligible for cancer screening, they are also familiar with the kinds of gossip, rumors, tall tales, and other folk knowledge about health and illness that circulates through local storytelling neighborhoods as a kind of “popular wisdom”. They are likely also to have “experiential knowledge” that would include personal experiences with “barriers” to accessing care. Gamson (1992) believes that media discourse often triggers political discussion in communities. He discusses the strategies social actors use to combine their “conversational resources,” pointing out that strategies that combine only parts of these three resources selectively tend not to develop “collective action frames” that mobilize actors. A strategy that combines personal experience, media discourse, and popular wisdom such that actors recognize the presence of social injustice, recognize an identity with and among other movement actors, and see pursuit of collective action as worthwhile, integrates conversational resources into collective action frames that motivate actors to become involved in collective action.

Figure 4: Tri-County Coalition by Organization: Size and Color of Lines
Illustrates Strength of Tie represents the range of organizations that provided members for the coalition. In all, thirteen organizations and communities are represented, seven of which are health care organizations, three are communities, two are county extension offices, and two were banks. Most coalition members across the region I talked with were public health professionals employed by the county public health departments or other local health care organizations. This was true for the Tri-County coalition as well. Many acknowledge having had a family member affected by cancer in their past. Only three of the eighteen coalition members in the Tri-County Coalition are cancer survivors. Coalition members typically embrace the discourse of cancer screening with its emphasis on personal responsibility and individual lifestyle change. Involvement in similar efforts like Operation UNITE, the regional drug coalitions, PRIDE, the regional program to address the region’s environmental concerns, along with participation in events like Relay for Life steeped these persons in a similar political outlook grounded in individual responsibility and familial obligation.

In the cancer prevention coalitions I observed, community participation beyond local healthcare providers was limited, if present at all, making most cancer prevention

Figure 4: Tri-County Coalition by Organization: Size and Color of Lines Illustrates Strength of Tie



coalitions inter-organizational networks embedded in community healthcare organizations as opposed to actual grassroots groups made up of community members beyond the healthcare profession. This embeddedness tends to reinforce assumptions based on standards of professional practice or in the criteria of federal and state policy concerning cancer prevention. In the interorganizational network diagram in **Figure 4**, the thickness and colors of the lines indicate strength of ties, based mainly on overall involvement levels among coalition participants. The three health departments, mainly via their tobacco control specialists, provide the greatest active involvement of members. These three members were active in grant writing, as well as in project planning and logistics. They were also engaged in regular communication about event staging and preparation, as well as in organizing connections with local media for advertizing purposes. Interorganizational involvement by health care organizations and county extension, and the prominence of the hegemonic discourse of screening would appear to point to considerable socialization into professional involvement. Indeed, I found no

representative from any low income or working-class neighborhood or community participating in the coalition.

Structure

The *structural location function* that Passy and Giugni (2001) speak of is the end point in the recruitment process whereby actors, by virtue of their embeddedness in community storytelling neighborhoods, or communication networks, come into contact with opportunities to participate. Within their framework, local actors are understood to be experiencing a degree of anxiety and uncertainty about their situation as a result of the concerns related to a potentially mobilizing issue, in this case, cancer and its prevention and treatment. Through strong ties to other trusted community members, potential recruits gain knowledge and information about the social movement and its activities and make decisions to become involved. Such a process is quite different from gaining information about a new job available in a community, for instance, which typically occurs through their weak ties to acquaintances as opposed to strong ties to other community members (Granovetter, 1973). Becoming empowered to participate becomes a matter of trusting important members of one's Lifeworld and supporting actions that mutually affect not just one's own well-being, but that of other community members.

According to the infrastructure metaphor, social network ties function like “roads” that affect the probability that further relationships will develop (Borgatti, 2005). Ties based on interactions and flows of information and resources have an effect more like “traffic” along the relational roadways. I examined the social network structure of the Tri-County Coalition through an interview process that collected data on who is affiliated with the coalition directly as a participant, who is indirectly involved through contributions of money and other resources, and whom the coalition draws upon to provide advertisement space in local media outlets. I gathered data on role relations as well as similarities in terms of education and perceived emphasis and effectiveness related to coalition activities. I also attempted to gather data on intra-coalition ties in terms of ten different interactions.

Response to requests for information somewhat disappointing, but I came to realize that there were significant differences among coalition members in terms of who actively participates in the micro-routines of the coalition and those who are more generally

“adherents” to the coalition (Passy & Giugni, 2001). In all, seven of the eighteen members of the coalition were regularly engaged in the internal activities of coalition.

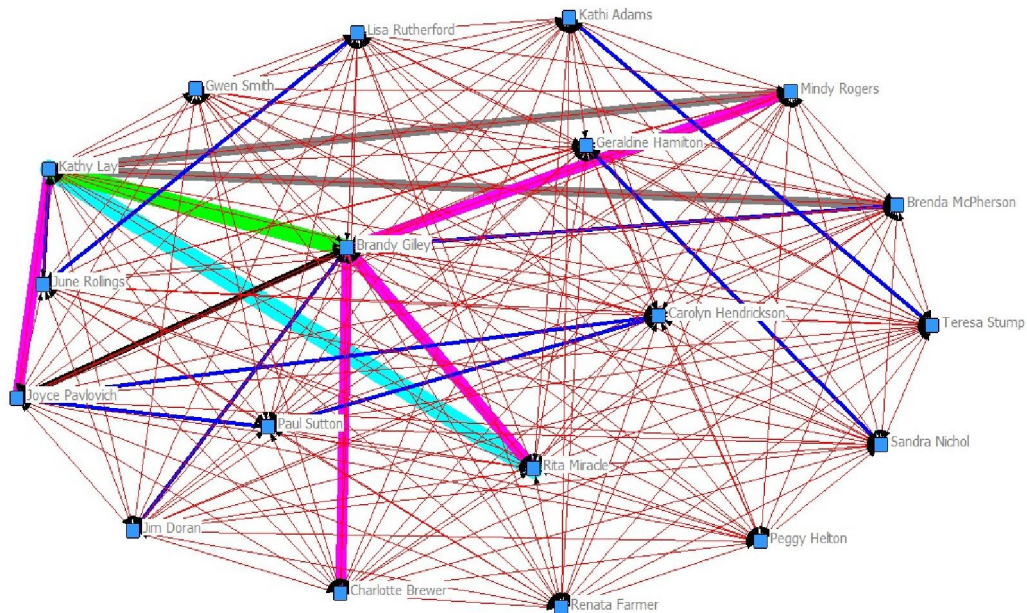
Figure 5: Tri-County Coalition by Person: Size and Color of Lines Illustrates

Strength of Tie is a composite network structure which combines all the sparse tie data I was able to put together to represent the core activity of the seven most active members of the coalition. Seventeen of the eighteen members were women and all eighteen were white. The core group was made up of the three Tobacco Control Specialists from three county public health clinics. Of those three, the coalition Secretary, my main informant, handled a considerable amount of the internal coordination of group activities, while a second Tobacco Control Specialist engaged in regular interaction with representatives of the Kentucky Cancer Program and from the American Cancer Society. The coalition Chairman was a cancer survivor from within the community, and was cited as a regular confidant in relation to internal coalition matters, but she did not carry out the kinds of organizational routines typically handled by the public health Tobacco Control Specialists.

The network structure depicted in **Figure 5** does not situate the coalition activity in relation to the geographic sites which provide a spatial and temporal context for cancer prevention activities. Coalition meetings are held every second Tuesday of the month and move around to a number of locations within the Tri-County area. Also, promotional activities are held in community sites such as local schools and at local businesses.

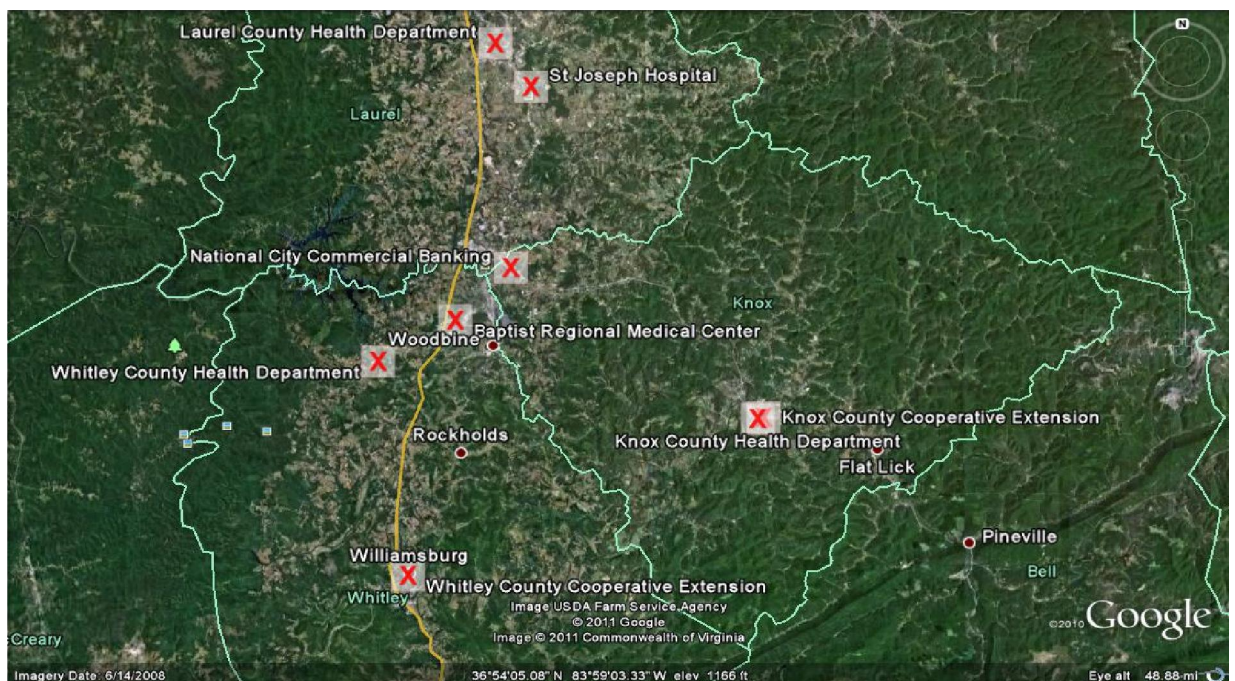
Figure 6: Tri-County Coalition's Area of Regionalized Activity locates the organizations that are primarily active in coalition routines within the geographic area of the three counties. Social settings that make up coalition routines include front stage promotional activities in which cancer prevention information is made available in the community and people are recruited for screenings and other cancer prevention activities. Another kind of front stage setting involves fund-raising promotions such as raffles. Backstage settings include coalition planning meetings, the interactions in and around performing and setting up front stage routines, and individual interactions whereby members provide each other with support and encouragement, or vent concerns or frustrations. The processes by which community members access funds to help with transportation costs to screening and treatment follow-up are also performed back stage

Figure 5: Tri-County Coalition by Person: Size and Color of Lines Illustrates Strength of Tie



to assure the privacy of those in need. Together, the sites and settings form the coalition's locale of cancer prevention activities and regionalize prevention activity within the three county areas.

Figure 6: The Tri-County Coalition's Area of Regionalized Activity



The Impact Mining on Regional Health and Inaction in the Face of Injustice

In **Table 2: 2006 Production by County and Type of Mine License**, we can see that fifteen of the sixteen counties in the two ADDs were coal producing counties as recently as 2006 when the data was produced. Though some counties produced more coal via underground mining, many counties no longer produced coal from underground sites. Surface mining produced coal in all fifteen of the counties where coal mining is part of the local economy. **Figure 7: Cancer Prevention Coalitions located in County Health Departments in Relation to Mountaintop Removal Sites** maps the county health departments of the sixteen counties in relation to the mountaintop removal sites identified by the environmental group iLoveMountains.org. The map allows us to see the proximity of mountaintop removal's environmental destruction to the counties involved in this study.

Efforts to engage coalition members on health care reform issues or concerns about the environmental effects of surface mining on community cancer rates fell flat. The only discussion of a political nature I was able to develop in my interviews concerned efforts by the federal government to change the breast cancer screening guidelines, which were seen as a backdoor maneuver during the healthcare reform debate to appease third-party payers who were feeling threatened by the reform effort. The relationship of regional cancer burden to mining, particularly mountaintop removal mining, appeared to be a topic that made people nervous. And the issue appeared to elicit similar feelings from state and university officials as well, as evidenced by a lack of related research produced on the issue at the University of Kentucky, the academic setting associated with the eastern regions of the Kentucky Cancer Program.

Bell (2011) argues that there has been significance and persistent efforts by coal operators in coal producing counties to reinforce the perception among coal communities that coal production is essential not only to the local community, but is also an essential part of community identity. In Central Appalachian counties “owners and managers of extractive industries actively construct, maintain, and amplify community economic identity in order to ensure that certain ideologies dominate in communities that historically depended on natural-resource extraction, thereby averting a legitimization crisis” (Bell, 2011). This makes maintaining and reinforcing community economic

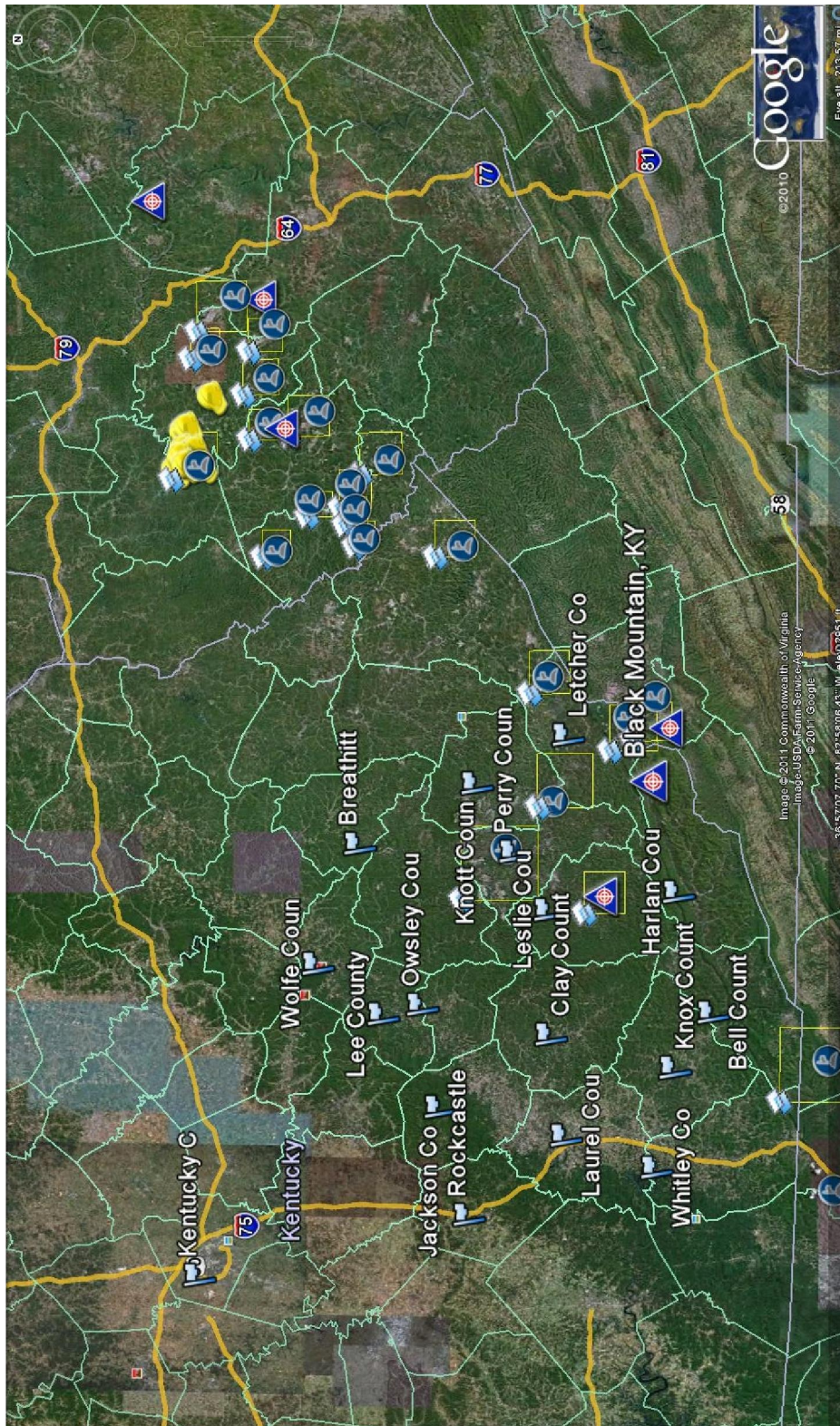
Table 2: 2006 Production by County and Type of Mine License*

<i>County</i>	Underground		Surface		Total	
	<i>License s</i>	<i>Tonnage</i>	<i>Licenses</i>	<i>Tonnage</i>	<i>Licenses</i>	<i>Tonnage</i>
Bell	8	1,012,546	23	1,742,281	31	2,754,827
Breathitt	2	-	7	1,598,788	9	2,286,454
Clay	3	101,536	7	94,819	10	196,355
Harlan	50	8,585,933	26	3,249,239	76	11,835,172
Jackson	-	-	7	66,036	7	66,036
Knott	31	5,317,885	22	3,662,497	5	8,980,382
Knox	10	221,085	10	453,037	20	674,122
Laurel	-	-	2	134,799	2	134,799
Lee	-	-	1	24,084	1	24,084
Leslie	5	3,096,748	10	1,789,424	15	4,886,172
Letcher	26	6,342,546	34	3,480,209	60	9,822,755
Owsley	-	-	4	106,125	4	106,125
Perry	10	4,154,284	28	9,884,628	38	14,038,912
Rockcastle	-	-	1	60,989	1	60,989
Whitley	1	20,774	1	148,712	2	169,486
Wolfe	-	-	2	6,294	2	6,294

*Source: www.kentuckycoal.org/documents/CoalFacts08.pdf

identity critical to avoiding a legitimization crisis that might occur if the costs of continued environmental destruction through mining are questioned too deeply or extensively. One way Bell (2011) found that community inaction is promoted in the face of the environmental injustices of mining is through the power of the local elite, who benefit

Figure 7: Cancer Prevention Coalitions located in County Health Departments in Relation to Mountaintop Removal Sites



from the maintenance of the status-quo. Though coalitions typically do not see themselves in this light, their institutionalization as a “social movement” heavily interpenetrated by federal and state agencies, private industry, and national cancer charities (Klawiter, 2008), reinforces the perception that they are part of that local elite. By practicing a consensus-based form of community mobilization within a narrow single-issue focus, they serve as experts instead of co-participants. The emphasis on a single framing of cancer health overwhelms any potential local discussion about the dangers of coal mining to regional health, thereby constraining goal setting and problem-solving with agendas from outside the local community.

Mountaintop removal has been associated with significant environmental pollution including a variety of carcinogenic substances, and along with other forms of coal mining, also associated as well with a range of health concerns including several types of cancer (Hitt & Hendryx, 2010). According to Hendryx, Wolfe, Luo, and Webb (2011):

Mountaintop mining (MTM), which is also called mountaintop removal mining, uses heavy machinery and explosives to strip vegetation and remove topsoil and rock to reach coal seams. The spoil from this activity is deposited in adjacent valleys that contain headwater streams. As of 2005, mountaintop mining had impacted 272,000 acres in southern West Virginia, eastern Kentucky, eastern Tennessee, and western Virginia. MTM is a public health concern because of the serious and long lasting environmental damage that it causes. One recent study found that 9 out of 10 Appalachian streams downstream from mining operations are contaminated with runoff from surface mining sites, and a 2010 memorandum from the Environmental Protection Agency states that 2,000 miles of Appalachian streams have been filled by surface mining practices. Surface water and ground water around MTM activity are characterized by elevated sulfates, iron, manganese, arsenic, selenium, hydrogen sulfide, lead, magnesium, calcium and aluminum; contaminates severely damage local aquatic stream life and can persist for decades after mining at a particular site ceases. In addition, elevated levels of airborne particulate matter around surface mining operations include ammonium nitrate, silica, sulfur compounds, metals, benzene, carbon monoxide, polycyclic aromatic hydrocarbons, and nitrogen dioxide. Residents near MTM sites complain of health concerns, air and water contamination, reduced property values and damaged family cemeteries, and experience psychological stress from fears of floods, landslides, flyrock, and the destruction of their natural heritage. State political figures support the coal industry and have done little to investigate or respond to citizen concerns (Hendryx, Wolfe, Luo, & Webb, 2011).

The congressional district that includes the sixteen counties exemplifies the critique made by Hendryx et al, (2011). All of the sixteen counties are included in the Fifth

Kentucky Congressional District (KY-05), which, according to the US Census Bureau (2000), is the second poorest congressional district in the US with a median household income of \$21,915 and a poverty rate of 27% (Half in Ten Project, 2007). It also has some of the highest rates of poverty in Kentucky as well. The district has the highest concentration of mining of any congressional district in Kentucky, while also having some of the highest rates of heart disease, kidney disease, (Hendryx & Zullig, 2009) and cancer (Hendryx, Fedorko & Anesetti-Rotherme, 2010; Hitt & Hendryx, 2010; Hendryx, Wolfe, Luo, and Webb, 2011) in the state. In many ways the district exemplifies the question asked by many environmental activists who oppose mountaintop removal – “If mining generally, and mountaintop removal specifically, is so good for the region economically, how come there is so much poverty and illness where it takes place?”

Residents of mountaintop mining counties reported significantly more days of poor physical, mental, and activity limitation and poorer self-rated health compared with the other county groupings (Zullig & Hendryx, 2011). Central Appalachian counties where mountaintop removal occurs had significantly higher mortality rates, total poverty rates and child poverty rates every year as compared to other counties in the region (Hendryx, 2001). The author concluded that people living in mountaintop removal areas have experience elevated poverty and mortality rates over time and that efforts to reduce health disparities in the region must focus on the Appalachian coalfields.

KY-05 is represented in the US Congress by Representative Hal Rogers (R-KY), who has been labeled the most "corrupt member of Congress" by the non-profit Citizens for Responsibility and Ethics in Washington. Of the 436 congressional districts, KY-05 ranked at the bottom of all US congressional districts in terms of Overall Rank, Life Evaluation, Emotional Health, Physical Health, and Healthy Behavior in 2010 and 2011 (Gallop Healthways Well Being Index, 2011). It was 421st in Basic Access to services in 2010 and 423rd in 2011. Rogers is, according to the report by Citizens for Responsibility and Ethics in Washington (2011), at the center of an interconnected network of organizations that includes several Kentucky nonprofit groups, a bank he partially owns, and several companies he has supported with federal money. Having strong ties to Rep. Rogers and to each other, the organizations work together to extend his influence. His private companies received \$227 million in federal loans, grants, earmarks, and contracts

since 2000. He also helped steer over \$236 million in taxpayer funds to seven nonprofits he helped create, including \$174 million in earmarks. The remaining \$63 million resulted from federal grants, at least some of which Rep. Rogers personally sought from federal agencies. Included among the non-profits set up by Rogers are the Center for Rural Development, Inc. (CRD), Forward in the Fifth, Inc. (FIF), Southeast Kentucky Economic Development Corporation, Inc. (SKED), Southern & Eastern Kentucky Tourism Development Association, Inc. (TOUR SEKY), Eastern Kentucky Personal Responsibility in a Desirable Environment, Inc. (PRIDE), Unlawful Narcotics Investigations, Treatment and Education, Inc. (UNITE), and the National Institute for Hometown Security, Inc. (NIHS) (Bresnahan, 2011).

UNITE and PRIDE operate as coalitions in much the same way as early detection and screening activism coalitions, espousing participatory community mobilization models that call for the local population to participate, but over time come to be dominated by professionals. Each comes to embrace top-down discursive strategies that promote professional, technocratic problem-solving even as they claim a "grassroots" constituency. My concern is that, because they all practice a similar kind of neoliberal participatory practice in which the community is encouraged to help make state agencies and collaborating non-governmental organizations more efficient, as opposed to more responsive to community needs, the coalitions reinforce the perception that local elites will not confront the coal industry about its impacts on the region's health. Target groups are identified and included in the development process of fund-raising, thus defining participation and empowerment within a harmony model of power so that empowering the powerless can be achieved within the existing social order and without any significant negative effects upon the power of the powerful. Someone can attend events and raise money, but must not question whether the acid or the red water running down a local stream has pollutants in it that can cause cancer. This format for participation becomes pervasive in the region and comes to be recognized as unable to make significant changes in the social conditions that lead to various disparities that plague local communities. The coalitions all frame local populations as in need of intervention in some way, promise community mobilization, and then simply reproduce the same technocratic solutions offered elsewhere without engaging in political action sufficient to challenge local elites.

Summary

The organizational impetus of the Tri-County Coalition ties casts doubt on the espoused “grassroots” nature of coalition activities. The Coalition limits its goals to increased numbers of cancer screenings and the provision of basic prevention education to their communities, along with grant writing and fund-raising as a means of covering additional costs that medically marginalized locals can accrue in following up on referrals for cancer screening. The Tri-County Coalition is one of two coalitions in the sixteen counties that have incorporated themselves as 501(c) (3) organizations and engage in local fund raising activity. Such activity, along with the promotional projects of the coalitions, is undertaken mainly within the seasonal cycle of national promotions by the American Cancer Society (Relay for Life in the spring) and by Astrazeneca (National Breast Cancer Awareness Month in the fall).

The Tri-County Coalition is the only multiple county coalition in the sixteen counties. It includes members from Knott, Laurel, and Whitley Counties in southeastern Kentucky. The coalition relies heavily on the activity of seven of its eighteen members to carry out most of the coalition’s activities. Of these seven participants, the three tobacco prevention specialists from the three county health departments demonstrate important leadership. The coalition has adopted the addition burden of attempting to fund-raise locally, using that money to provide some aide to local persons who are in need of help with transportation costs to and from cancer screening and treatment activities. This fund-raising and subsequent distribution of moneys to local persons in need creates surveillance concerns for the coalition, generating additional efforts to monitor how money is spent for fear that the local community will perceive the donate funds are being misused.

Because the coalitions practice a kind of neoliberal participatory practice in which the community is encouraged to help make state agencies and collaborating non-governmental organizations more efficient, as opposed to more responsive to community needs, they lose the ability to confront local elites and power structures. Target groups are identified and included in the development process of cancer prevention coalitions, but for the most part, the groups are made up of local professionals committed to advancing their interests within the technocratic solutions of their specialties. They define

participation and empowerment within a harmony model of power so any empowerment of the powerless can only be achieved within the existing social order and without any significant negative effects upon the power of the powerful. This format for participation has become pervasive in the region and recognized as unable to make significant changes in the social conditions that lead to various disparities that plague local communities. The coalitions all frame local populations as in need of intervention in some way, promise community mobilization, and, in the end simply reproduce the same technocratic solutions offered elsewhere without engaging in political action sufficient to challenge local elites.

In the next chapter, I will examine cancer prevention as a regional social problem. I want to use social network analysis to visualize the extent of connection across coalitions to understand spatially how the coalitions are helping to institutionalize a particular cancer prevention discourse, and, in doing so, institutionalizing a reconstruction of Appalachian identity in line with the current tendencies of neoliberalism and advanced capitalism that is part of the “prevailing social attitudes” (Duffy, 1992) of the times. The institutionalization process started in Kentucky in 1992 with the Appalachian Leadership Initiative on Cancer (ALIC) and has continued since that time.

In chapter four, referral networks related to colorectal cancer are discussed in terms of how travel distance affects referral rates. Local referral rates appear to be influenced by common sense understandings of the distance one must travel for screening and this would appear to affect whether or not referrals are made in the first place. In the three chapters after that I will explore the impact of newspaper discourse on how a local cancer coalition is situated within the local health care social world. I want to illustrate how cancer-related stories appear in newspaper discourse networks and the ways such stories compete for community attention in a region where other more immediate public health concerns tax local resources. In particular, the community in question struggles regularly with destruction of property and public water and sewer systems due to mountaintop removal mining. I will review these discourse networks and use them as a basis for analyzing the local cancer prevention coalition network.

Chapter Four: Cancer Prevention as a Regional Social Problem

Cancer as a Social Problem

My purpose in this chapter is to develop an understanding of the issue of cancer prevention in eastern Kentucky as not only a medical problem, but also as a social problem. In doing so, I want to further expand the use of social network analysis to visualize the extent of connection across coalitions to understand spatially how the coalitions are helping to institutionalize a particular cancer prevention discourse. In doing so, they are helping to reconstruct Appalachian identity in line with the current tendencies of neoliberalism and advanced capitalism that is part of the “prevailing social attitudes” (Duffy, 1992) of the times. The connections within and among coalitions has been sustained through the participation of coalition members over time. This is a process that started in Kentucky in 1992 with the Appalachian Leadership Initiative on Cancer (ALIC) and has continued since that time. Cancer prevention discourse has become an important element in the “identity of the region” (Paasi, 2003), offering a discursive field that suggests a horizon of meaning (Laclau, 1996; Chouliaraki, 2005) about “nature, culture and people that are used in the discourses and classifications of science, politics, cultural activism, regional marketing, governance and political or religious regionalization” (Paasi, 2003) to distinguish the Appalachian region from other regions of the country. Public health institutions in the region have thus operated as “region-building institutions”, utilizing the history of social, economic, and environmental distress as justification for continuing to address “health disparities” in the region. Coalitions have become a vehicle for institutionalizing the “identity of the region” by positioning that identity in relation to mainstream discourses about cancer prevention.

At the level of “regional consciousness” (Paasi, 2003), the idea of “cancer survivor” has become an identity available to many who have endured cancer treatments. The question as to whether “survivor” still marks any of the original New Social Movement attributes that were evident in the Women’s Health of the 1970s that originally were used to voice concerns about the health and well-being of marginalized populations of women are still evident is taken up here as well. Have the influences of other forces affecting the rise of Early Detection and Cancer Screening Activism colonized the identity and the activities from which it arose? Klawiter (2008) states that this culture of action has

become quite complex and it is very difficult to separate the interests of the national network of academic cancer researchers and educators, private industry, and non-profit entities interested in cancer. It is the sheer “mundane-ness” and “everyday-ness” of mainstream messages about cancer, cancer prevention, and cancer treatment that are the focus of this study.

Identifying local coalitions as “community-based” and “grassroots” suggests one chain of equivalences (Laclau, 1996) that re-identify populations at risk for cancer in the region as worthy of subsidized financial support for their medical issues. By describing coalitions this way, they become part of a tradition of using “discourses of uplift” in Appalachia in an attempt to bring indigenous populations in line with Modernist development projects (Billings, 2000). The discourse of community participation attempts to solve what has been called “the problem of justification” (Boltanski & Thevnot, 1991; Sulkenen, 2009), while also operating as a “governing image” (Room, 1978) that provides social rubrics and specific models for shaping how cancer prevention will be enacted regionally. Coalitions are one of several biomedically oriented organizations that are given “custody” of the intractable problem of cancer, even as acceptance of this custody involves a tacit commitment to a “discourse of hope” (Vecchio-Good, Good, Schaffer & Lind, 1990) that denies the continued intractability of the issue.

More abstractly, the common good of the nation has been defined in the US largely in terms of technological progress and economic growth, which in turn derives its moral authority from the ways it supports various pursuits that give peoples’ lives dignity and greatness (Sulkenen, 2009). The identities and lifestyles people construct through their individual choices help to establish and maintain social bonds in a community of people that share similar ideas about progress, dignity, and greatness. Under neoliberal economic policies, though, the historic practices of social security, which not only included welfare provisions like Medicaid, but also labor policy supports for collective bargaining that could secure health insurance, and retirement supports like Medicare for workers, have come into question as advocates of the free market in medicine have sought to exploit existing health care subsidies as well as increasing the flow of capital into privatized medicine (Evans, 1997). Horton (2006) argues that neoliberal restructuring of healthcare

along privatized and corporatized lines means clinical workers on the frontline in marginalized communities must balance institutional demands for greater accountability, productivity, and efficiency against the additional “emotional labor” needed to sustain patient goodwill in the face of underfunded, limited services (Hochschild, 1983; Lamphere, 2005; Leidner, 1999). Healthcare providers:

...for the underserved frequently bear the brunt of providing adequate care in an underfunded public health system. Demands for greater system “efficiencies” depend upon the uncompensated and unseen work of mid-level professionals who are often disproportionately female and minority. While their “roles have often been overlooked in the analysis of health care reform”, the restructured health care economy demands that such mid-level professionals perform the role of “flexible woman” (Horton, 2006, p. 2709).

Performing the “emotional labor” inherent in the service occupations while attempting to meet the ever-faster pace of health care production takes its toll on local health care workers and sets a very basic limitation on the time and energy cancer prevention coalition members have in advocating for those they serve (Horton, 2006). Because of restrictions in public health care financing, providers cannot completely insulate patients from the cost-cutting imperatives of their managements. Cancer survivorship has emerged as a valorized cultural identity in parallel to the political struggles shaping the financing of medical care. Survivorship originally carried the connotations of the Women’s Health Movement that advocated for women having a greater voice in their health care, but now has been largely co-opted by mainstream medical thinking, implying heroic struggle against disease, aided by the technological prowess of modern biomedicine.

Increasing instability in coal-based labor in Appalachia has eroded an important source of health insurance for workers as the historic system of union-supported care has disappeared (Krajcinovic, 1997). The entry of women into the region’s labor market as part of the growing service economy has done little to alleviate this instability and possibly only increased it, since many women working in retail, health care, and other forms of care taking employment experience low wages and minimal or no benefits (Miewald & McCann, 2004). Kinship ties are also strained as both parents must work, making traditional support of children and the aged difficult, if not impossible. Though programs that use para-professionals like lay health workers are often framed as supports

for marginalized populations who need help navigating an increasingly complex health care system, one can also see the deployment of “health navigators” as an attempt to create a structural fix for the decline of kinship ties in a region where out migration to seek work is common and the efforts to globalize the regional economy opens healthcare in the region to increasing corporatization and privatization.

King (2009) has argued that the “pink ribbon culture” of mainstream cancer prevention is aligned with middle-class consumer culture and perpetuates a particular understanding of the public sphere based on consumption-based participation of the “citizen-consumer”. Naïve acceptance of such an understanding of health identities is likely, then, to be misaligned with the interests of working class and other marginalized groups. A claim that cancer prevention coalitions are “community-based” and “grassroots” implies a particularized impetus for identity claims of survivorship as if they emerge locally out of a need embedded in local social relations, shared lifestyles, and social understandings about what is culturally appropriate in a given community. It also suggests that the identities of coalition members intersect not only with survivor stories, but from their own everyday professional and biographical paths as they are part of discourses of “community” and “region”.

The identity of “survivor” functions as the orienting identity around which particularized structural connections is thought to mobilize participants in the Early Detection and Screening Activism culture of action. Promotional discourses rely on survivor images to valorize those who follow biomedical recommendations to pursue regular screenings, as well as those persons who adhere to cancer treatment regimes. It also activates sympathies among persons not experiencing cancer, often by eliciting sentimental feelings about persons one has lost to cancer. This combination of valorizing promotional discourse and triggering sentimental ancestor reminiscence is a powerful rhetorical move that appears to hail a person in a very particular and intimate way, yet is used generically to support the universal horizon of meaning in the Early Detection and Screening Activism culture of action that heralds the wonders of technological biomedicine even as it tries to elicit contributions to pay for the research that seeks to develop those wonders. It obscures how professional emotional labor is being exploited to prop up markets for cancer services in underserved communities by assuring that a

portion of subsidized funding will be channeled into cancer prevention activities. It also glosses over how “participation” is often about co-creation of value through encouraging the use of specific cancer prevention services rather than political dialogue about how conditions in the region may be exacerbating the need for those services in the first place.

I assume throughout this study that “health disparity” is best understood as a euphemistic discursive symbol used to frame how social, environmental, and economic constraints of the larger healthcare system limit the health care choices available to “medically marginalized” social groups. The euphemism appears to be phrased as much to avoid explicitly making judgments as to whether these constraints are unjust or not as they are to clarify their basis. The euphemism masks the failure of US health statistics to track health inequities through class-based statistics (Krieger, Chen, Waterman, Rehkopf & Subramanian, 2005). It also masks decisions to reframe issues of race in terms of ethnicity, thus shifting attention to the culture of at-risks populations rather than the intersection of gender, race, and class as it impacts health care (Spalter-Roth, Lowenthal & Rubio, 2005). The use of community-based coalitions is a discursive practice and collection of organizational strategies which allow communities to make decisions about how to make medical access available to marginalized populations as well as to make decisions about how best to allocate local resources to accomplish the service delivery. Politically, this resembles efforts by conservative politicians to return issues of social safety nets to states and local communities, making austerity policies in federal government more likely. Blame for policy failures is also bumped down the hierarchy as the community becomes responsible for its failures to provide care, not the state or private healthcare providers.

Bumping the judgments down to the community level does not magically assure that injustices will not continue where they already exist or that new injustices will not arise. Even though the Kentucky Women’s Cancer Screening Program has helped to make Medicaid funding available to low income women in the region, it does not support travel expenses or food expenses for those persons involved. Such expenses are often beyond what marginalized populations can afford. They are further compounded if screenings are positive and result in further medical intervention. In the case of cancer prevention coalitions in the eastern Kentucky counties where this research was done, the

recommended solution has been to encourage coalitions to apply for 501C (3) status. This is intended to allow coalitions to put themselves on “equal” footing with other non-profit organizations in terms of seeking grant support for their activities and in developing fund raising strategies to fund activities like transportation support. In a strange twist of modern law, in order for a community-based group to be recognized, it has to establish a kind of “corporate personhood” to have legal standing in relation to the funds it raises.

Faith in technological, biomedical solutions to solve an intractable set of economic and environmental factors affecting cancer rates appears to place eastern Kentucky in the midst of current debates concerning the extent to which marginalized populations "should" manage their behavior and economic resources to minimize their risks for cancer and/or take appropriate actions for the early detection and prevention of the disease. This debate is part of a larger mainstream governance discourse that has been seeking to justify a withdrawal of the state from social safety nets and extensive corporatizing and privatizing of medical care, as well as externalizing health benefits to workers rather than making them part of employment benefits (Pollitt, 1982; Bazzoli, 2004; Havighurst, 2004). It does not question whether there are “upstream” exposures related directly to the amounts of toxins in the environment related to coal production, externalized costs of subsidizing the coal industry that are being pushed off onto local communities, or whether investments in education and the development of a different basis for the regional economy (Epstein et al, 2011) might better address the cancer burden in the region. Scott (2010) situates this issue clearly by discussing the region’s history as a national sacrifice zone that has repeatedly suffered chronic poverty and environmental destruction in the name of the higher purpose of energy security.

Less dramatically, the repeated accusations of Medicaid fraud that have become part and parcel of receiving that funding haunt efforts to ameliorate economic injustice through the welfare state. The national discourse connects a “prevailing social attitude” (Duffy, 1992) about the place of government in our daily lives and a desire to roll back the welfare state to the ways local groups feel under pressure to account for the moneys they do collect through fund-raising and grant writing. The importance of this theme is in the way it provides rationale for converting social security to civil security (Castel, 2002). Criminalizing Medicaid fraud has been justified in light of efforts to make those who

distribute medical subsidy more “accountable”, as well as “efficient”; the identification of Medicaid fraud has become a rhetorical device by which conservatives delegitimize publically funded social safety net activities like Medicaid. A common theme that surfaced when talking to coalitions members who were involved with fund raising was the fear that those they helped, typically through giving gift cards for gasoline, would be seen in the community using that card to purchase cigarettes or other “luxury” items, redefining the coalition’s fund raising activities with a taint of corruption that was intolerable.

The above discussion suggests that the classic definition of “social problem” from Spector and Kitsuse (1977) applies, then:

Our definition of social problems focuses on the process by which members of a society define a putative condition as a social problem. Thus we define social problems as the activities of individuals or groups making assertions of grievances and claims with respect to some putative conditions (Spector & Kitsuse, 1977, p. 77).

With this definition in mind, cancer prevention becomes an issue taken up in local storytelling associated with notions of community and selfhood as it competes for a place in the social world of the region in public health. Coalitions, and the organizational entities associated with them, function as a kind of storytelling neighborhood (Kim & Ball-Rokeach, 2006) that seeks to define what it means to belong to a community through lifestyle themes in local communities. Another source is the local news media, probably best represented by local newspapers which circulate stories about cancer and cancer prevention, as well carry advertisements for cancer prevention promotions. At a national level, the most commonly recognized public face of cancer prevention in media promotions reflects the success of certain “communities of operatives” (Hilgartner & Bosk, 1988), most notably large-scale non-profit organizations like the American Cancer Society and the Susan G. Komen Foundation, along with such government agencies as the National Cancer Institute and the Centers for Disease Control, to define cancer prevention in the terms that Klawiter (2008) calls the Early Detection and Screening Activism culture of action. This includes the mainstream, “pink ribbon” culture (King, 2008) that is focused primarily on breast cancer as a women’s health concern; fund raising is coupled with “awareness” building through a number of “Run for” campaigns

that call attention to the incidence of cancer and pay homage to successful “survivors” of the disease who have followed medical treatment directions and lived through the cancer treatment process. It also is threaded through with national level objectives promoted mainly by the National Cancer Institute, the American Cancer Society, and the Centers for Disease Control to disperse the most recent research findings and best treatment practices to communities.

Within a social problems perspective, the focus is typically on the phases of social processes by which different groups attempt to make claims about the incidence of cancer, including concern about people’s “awareness” of cancer incidence in the region. Lack of awareness is tied to concerns about the lifestyle choices that make the population vulnerable to developing different cancers and associated with mother-daughter and other female, familial commitments. The proposed preventative solution for those persons “at risk” is to change unhealthy lifestyle patterns in favor of actively seeking regular screenings to assure that cancer is not developing unseen in some site in the body. It also includes “taking action” in the form of consuming the vast array of “pink ribbon” products on the market. Awareness building and promotion of healthy lifestyle have become ubiquitous to cancer prevention health promotions and if there is a grievance that is asserted anywhere in the messages of this kind of claims-making, it is against the disease of cancer itself. Awareness building, lifestyle change, regular screening, and participation in promotions and fund raising drives are touted as, in a sense, as a way to “stand up to cancer,” to “fight back” against the disease.

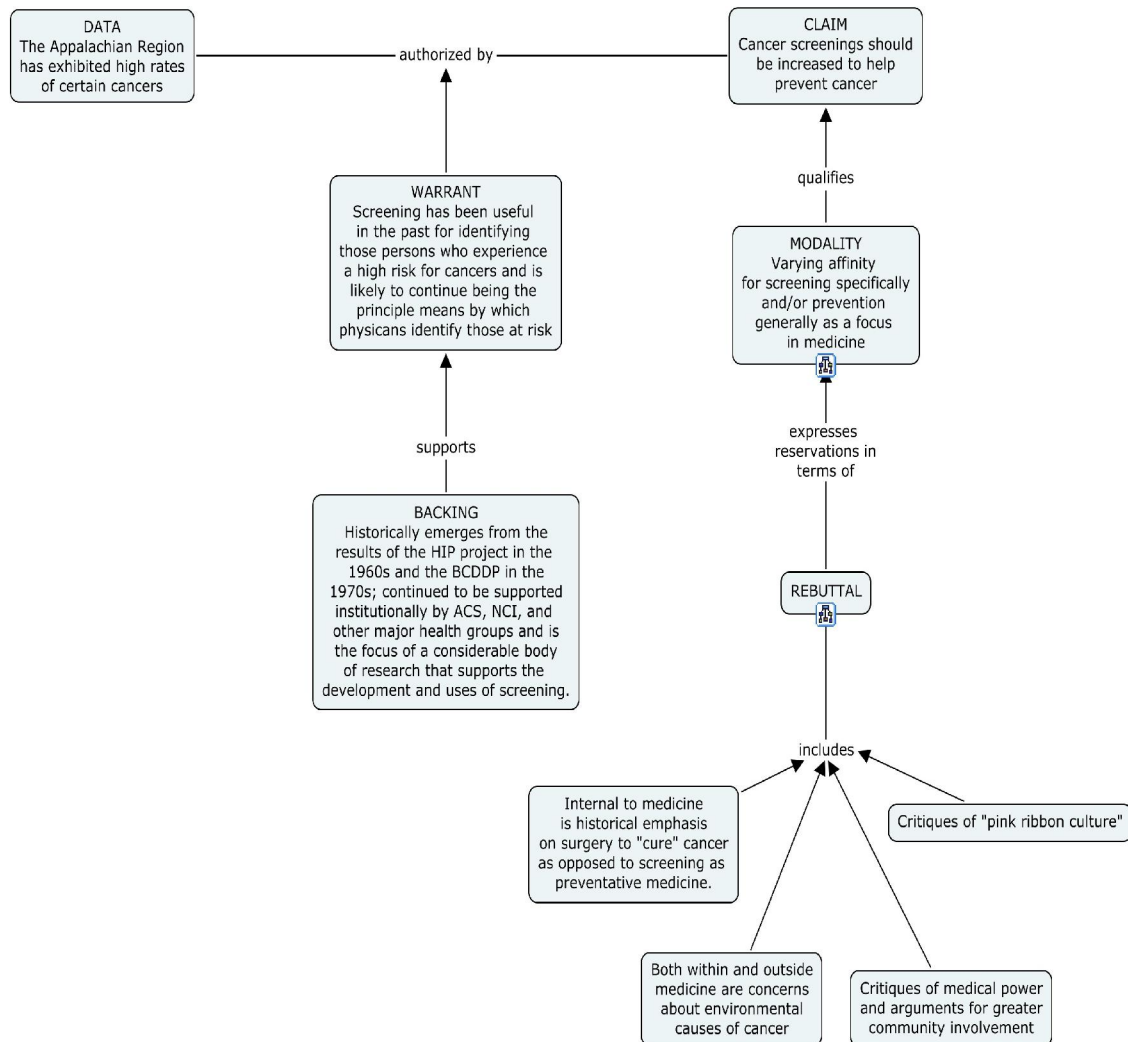
“Pink Ribbon” Culture at Center Stage: The Public Face of Cancer Prevention

Hilgartner & Bosk (1988) suggest we not focus so much on identifying the stages by which a definition of a social problem emerges, but instead on the ways that competition among different definitions takes place in public arenas over time, arenas that include struggles by various parties to control how issues are framed:

...we assume that public attention is a scarce resource, allocated through competition in a system of public arenas (Hilgartner & Bosk, 1988, p. 55).

We can depict the basic elements of the claims made by particular mainstream cancer prevention organizations like the National Cancer Institute and the American Cancer Society as a type of argument by using a Toulmin diagram (see **Figure 1**) (Toulmin,

Figure 1: Cancer Prevention Claims as Toulmin Diagram



1958). The basic claim involves not only the recognition that the Appalachian region has exhibited high rates of certain cancers (lung, colon, and cervical cancers), by the core element of the claim authorizing the encouragement of Appalachians as a “risky” population to utilize various forms of screening to help detect and prevent cancers before they can become life threatening. This authorization has been warranted by a tradition in cancer research that has searched for technologies of early detection that dates back to at least the 1913 when radiation was first used to image the breast (Klawiter, 2008). It was not until the late 1960s that the use of “dedicated” mammography machines began to be commercially available. This was in large part due to resistance to using mammography diagnostically among surgeons, who preferred surgical biopsy to detect the presence of

cancer in tissues. In spite of this resistance, the interpenetration of the state and private industry into cancer screening advocacy and the rise of mass-participation fund-raising events like “Run for the Cure” and National Breast Cancer Awareness Month helped to popularize cancer screening as a method of early detection (Klawiter, 2008).

The current mainstream definitions of cancer prevention did not evolve over night, but emerged over time as different institutional actors have competed and struggled to get their definitions heard and accepted. A cancer-focused infrastructure that circulates and maintains the prominence of mainstream messages has been under construction from at least the early 1970s when President Nixon proclaimed a “War on Cancer”. Klawiter (2008) suggests that this discourse has emerged from the overlap of government and private industry investments in research and the distribution of its results, the rise of mass fund-raising activities by the on-profit sector concerned with cancer, and the political advocacy of the Women’s Movement to get recognition of the cancer burden carried by marginalized populations in various regions of the US. The infrastructure has been and still is being shaped symbolically through time by a shifting relationship between the Universal and the Particular, between the changing horizon of meaning (Laclau, 1996; Chouliaraki, 2005) used to frame cancer as a public health issue in political policy, the media, academia, and the chains of equivalence used as evidence to justify claims about the continuing importance of cancer to the public health which has crystallized in the various ways that those who make it through cancer treatment come to be constructed as “survivors” (Crossley, 1997, 1999; Little, Paul, Jordens, & Sayers, 2002; Orgad, 2009). The objectives of various competitors have been absorbed into the horizon of meaning and operate, sometime in concert, other times at odds with one another, such as claims made by the Women’s Health Movement of the 1970s and the recognition and co-optation of breast cancer as a “dream cause” by corporate philanthropy in the 1980s and 1990s (King, 2008). As the infrastructure has been instantiated materially, a number of interests have become institutionalized even as others have lost ground and faded from the arena.

...All public arenas, operatives, and members of the public have finite resources to allocate to social problems. Allocation decisions are made to pursue a variety of goals. Newspaper editors, e.g., may work to attract readers and advertizers, maintain professional standards, exert political influence, and advance their

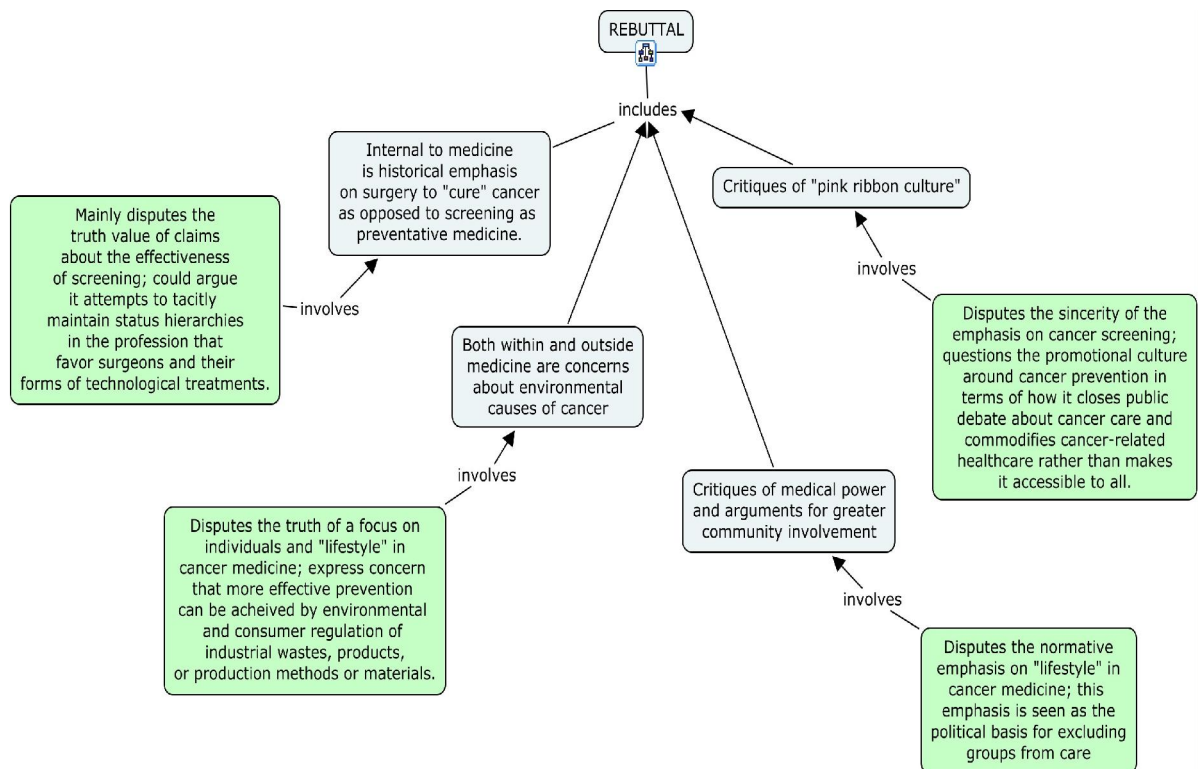
personal careers, while nonprofit groups may work to ensure organizational survival, capture funding, expand their base of support, and achieve their policy goals. It is common for operatives to attempt to influence the resource expenditures of one another. Thus, politicians will work to capture media attention by staging events that editors will see as good stories, foundations will do evaluations designed in part to influence the activities of grantees; and TV producers will struggle to capture the attention of viewers (Hilgartner & Bosk, 1988, p. 60).

“Pink Ribbon” culture enacts a yearly cycle of events and promotions that emphasize the dramatic struggles of cancer survivors. When most of us think of cancer prevention we are likely to remember encounters with have had with people earnestly displaying pink ribbon paraphernalia, viewing awareness raising commercials or advertisements in the media, or walking or running in a local “fun run” to encourage donations for cancer research. These are primary front stage activities that bring cancer prevention into everyday experience, and they strongly structure the course of local promotions in eastern Kentucky. The coalitions I researched were likely to time their local cancer prevention promotional activities in relation to this national cycle of events. Scheduling health fairs and Ladies Day events, free screening clinics, and newspaper stories about cancer prevention are a means by which coalitions honor their commitments to the larger cancer prevention project while keeping the effort to reach beyond the demands of daily obligations in their respective health care or other employment settings within manageable limits.

Summarizing the Rebuttals

Figure 2: The Rebuttals and Modality summarizes the objections to the claim that “Cancer screenings should be increased to help prevent cancer” in the region. One rebuttal emerges internally from medicine and involves the historical emphasis on surgery to “cure” cancer as opposed to screening as preventative medicine. This rebuke mainly disputes the truth value of claims about the effectiveness of screening. One could argue that this rebuke attempts tacitly to maintain status hierarchies in the medical profession that favor surgeons and their preferences for surgical intervention. Additionally, both within and outside medicine, there exist concerns about environmental causes of cancer. This rebuttal disputes the truth of a focus on individuals and “lifestyle” in cancer medicine. It claims that more effective prevention can be achieved by

Figure 2: The Rebuttals and Modality



environmental and consumer regulation of industrial wastes, industrial products, or production methods and materials. In the meantime, the coal industry has gone on the offensive to control the nature of the regional regulatory debate, engaging in a series of high profile campaigns to promote “clean coal” technology and to discredit regulatory policies (Bell, 2011; Bell & Braun, 2010; Bell & York, 2010; Scott, 2010a; Scott, 2010b).

The Cancer Prevention and Environmental Risk culture of action (Klawiter, 2008) makes strategic use of science to confront the manner in which the environmental regulations are circumvented by industry or by which deregulation opens communities to toxic environmental exposures. Recently, “citizens” groups like Kentuckians for the Commonwealth in eastern Kentucky have been utilizing legal and academic research to confront fraudulent coal industry claims about surface mining, such as the idea of “clean coal” technology. They have begun to enlist public health research that exposes the profit-driven exploitation of the environment in the region and its impacts on the health and well-being of eastern Kentucky communities (MACED, 2009). This strategy has had difficulties breaking through to coalitions, and has had little support as well from academic and state institutions related to the mainstream cancer prevention infrastructure.

It is significant that over the past decade coal the industry has responded to the legitimization crisis created by the decline in coal employment and increasingly intense local backlashes against the destruction of the regional environment by Mountaintop Removal (MTR) by engaging in an extensive ideological campaign to link the coal industry's fortunes to regional economic identity (Bell & York, 2010; Bell & Braun, 2010). This has had the effects of amplifying historic associations to local communities by shaping perceptions of "coal heritage" as a defining feature of the region. It also has provoked fears among male workers who seek to remain employed in high paying coal employment, with the industry engaging in a variety of cultural manipulations to play on patriarchal belief systems in the blue-collar moral community of industrial workers and keep them fearing for their livelihoods (Scott, 2010). At the same time, this manipulation distracts attention from the growing dependence of regional households on women's work outside the home in low-paying retail, caretaking, and service employment (Miewald and McCann, 2004). The ideological reconstruction of the region's economic identity legitimates environmental destruction in terms of the value of coal employment even as the region continues to be represented as persistently poor. Representing the region as "persistently poor" misses the heterogeneous, cyclic pattern of prosperity and decline that has emerged as the region's mining industry has changed and the regional economy has sought to incorporate a service economy. Services constitute approximately 33% of regional employment, and retail trade and government another 25%, surpassing the 16% of employment now attributed to mining. This transition has made it necessary for women to enter the labor market, largely as service employees.

Critiques of medical power and arguments for greater community involvement emerged with the community medicine movement in the 1960s and were taken up by the Women's Health Movement in the 1970s. This discourse disputes the normative emphasis on "lifestyle" in cancer medicine and sees the potential in medicine for a political basis for excluding groups from care. Klawiter (2008) describes this discourse and the forms of activism that accompany it as the Patient Empowerment and Feminist Treatment Activism culture of action. It includes activism that focuses on the needs of marginalized populations, including the concerns of the Gay, Lesbian, and Transgendered community. For the most part I include this rebuttal here to give as broad as possible a depiction of

the rebuttals that exist in relation to claims for the use of cancer screening to address high levels of cancer in the Appalachian region. I found little evidence, however, that this discourse has influenced various actors I examined from the region.

Lastly, critiques of "pink ribbon culture" (King, 2009; Ehrenrich, 2010) dispute the sincerity of the emphasis on cancer screening in mainstream cancer prevention discourse. Questions about the promotional culture around cancer prevention focuses on how it closes down public debate about cancer causes and care while commodifying cancer-related healthcare rather than making it accessible to all. These complaints are directly related to the rise of mass fund-raising activities by large-scale non-profits like the American Cancer Society and the Susan G. Komen Foundation (Klawiter, 2008; King, 2009). Ehrenrich (2010) suggests that the constant incitement to engage in "positive thinking" that has become part of mainstream cancer prevention culture has been shown to have no real impact on the effectiveness of intervention and can actually hinder a person's ability to respond realistically to the complications of the disease and its treatment. She goes further and suggests that the "brightsiding" of positive thinking has become part of a larger trend related to collusion between corporate human resource management, advertizing and market fundamentalism that promotes the belief that positive thoughts "attract" health, wealth, and well-being to the positive thinker. She suggests that the "irrational exuberance" that accompanies market booms and busts under deregulated capitalism are underpinned in the US by the tendency to reward brightsiding as a way to not "rock the boat" in corporate work settings. Brightsiding and blind optimism become ideological devices that encourage people to ignore the "sensitive issues" related to health disparity, making open discussion difficult, if not impossible. They also have the potential to make avoidance of controversial themes like the impacts of coal mining on cancer rates in the region easier than undertaking the destabilizing discussion of public health research that finds connections among coal production, environmental degradation, and cancer rates in Appalachia.

"Health Disparity" as Backstage

The Modality section of the Toulmin diagram focuses attention on varying affinities for the claims made by mainstream cancer prevention culture, with the rebuttals listed above in **Figure 2: The Rebuttals and Modality** illustrating discursive variation this

lack of affinity implies. A less public face of cancer prevention concerns issues of “health disparity”, underscoring how expansion of mammograms and other screening practices have been extended to reach medically marginalized communities. This is part of the legacy of the Women’s Health Movement of the 1970s and is the third development, along with the interpenetration of the state and private industry into cancer screening advocacy and the rise of mass-participation fund-raising events (Klawiter, 2008). This chapter explores how coalitions attempt to address the disparity issue and later chapters discuss the impact of the more public, front stage emphasis on shaping the horizon of meaning that frames particular efforts to address disparity concerns. Coalitions are “insiders” who champion the institutionalization of a particular spatial division of labor supported at state and national levels among mainstream cancer prevention organizations:

Most social collectives, such as ‘nations’, are identified as imagined communities where spatial boundaries may be important constituents, but, besides ‘imagination’, these collectives exist firmly in social practice. Similarly, ‘regions’ are based at times on collective social classifications/identifications, but more often on multiple practices in which the hegemonic narratives of a specific regional entity and identity are produced, become institutionalized and are then reproduced (and challenged) by social actors within a broader spatial division of labour. Regions, their boundaries, symbols and institutions are hence not results of autonomous and evolutionary processes but expressions of a perpetual struggle over the meanings associated with space, representation, democracy and welfare. The institutionalization of regions may take place on all spatial scales, not only between the local level and the state. Actors and organizations involved in the territorialization of space may act both inside and outside regions (Paasi, p. 804-805).

If region is a “meeting place of human agency and social structure,” as geographer Nigel Thrift (1983) has described it, then it is also characterized by the paradox of Modernity (Oakes, 1997), the contradiction that follows from how human freedom and liberation are enabled by modern technology and other forces of modernization even as the totalizing tendencies of those forces threaten to overwhelm that freedom through oppressive forms of rationality and standardization. Health promotion, “addiction” and other self-characterizing discourses that frame health problems as failures of will are “technologies of self” (Foucault, 1988) intended to start people on a path to self-reconstruction designed to teach “the collectively fashioned, mutually recognized, and endlessly rehearsed predicaments of attempting to improve health in a world of

apparently unhealthy enticements (Crawford, 2000)” that have come to make up the rituals of health promotion. As Crawford has stated, health promotion,” including the conflicted and inconsistent adoption or rejection of medical prescriptions and proscriptions, can be understood as a ritual which attends to ‘matter out of place’: a contradiction in structure – at once material and symbolic – which is the source of a conflict in experience for contemporary Americans (Crawford, 2000).”

In the US, “imagined communities” (Anderson, 1991), whether on the scale of the nation or the region, are struggling with “meanings associated with space, representation, democracy and welfare” through efforts to reframe the metonym of “lifestyle” within market metaphors by understanding healthcare as consumption practice. Cancer prevention discourse acknowledges the place of some lifestyle behaviors as consumption, like tobacco use and overeating, while ignoring other addictive behaviors like drug abuse and alcoholism. Part of this is the result of scientific studies that do not necessarily correlate drug abuse and alcoholism with cancer causation. The issue of health disparity opens up the question of how addictions, which often are threaded through the lifestyles of low income and other marginalized populations, add to both the marginalization of that population and to the economic and social issues that affect that populations health. I would suggest that there should also be concern for the ways “addiction” and “lifestyle” can become totalizing discourses that make discussing the ways human agency and social structure meet in everyday routines difficult. The discourses turn efforts to address health problems into standardized interventions that no longer adapt to meet the changing conditions on the ground. Lifestyle and addiction discourses combine with the euphemistic discourse of health disparity to try to establish a basis for a technological fix for contradictions in the financing of health care that has become progressively more about profit-taking than delivering on universal rights. The reliance on a technological fix is part of a larger technocratic regime that seeks to depoliticize health issues and make them more amenable to inclusion in the profit-taking that exploits health financing subsidies even as it makes claims about the purity and efficiency of market solutions in healthcare. The hidden “sensitive issue” (Warren, 2006) that threads its way through discourses on Appalachia involves the status inequities related to the patriarchal position of male breadwinners, typically coal miners, in relation to those who work in other labor

sectors. The efforts to make subsidized health care available to other status groups is marked by forms of shame and disdain passed down the status hierarchy that is embedded in regional discourses about poor whites:

Recurrent stories of white trash, hillbillies, and other poor whites reflect the dissonance between ideal images of American citizens and realities of lived inequalities. Poor whites are matter out of place in the cultural map of the United States, which identifies poverty with blackness and wealth with whiteness...white trash discourse does more than just stigmatize poor whites. It also disciplines an ideal “white” subject through these processes of repudiation and abjection. These “disidentifications” reaffirm the logic of differential worthiness, which teaches that those who cannot make it are themselves to blame, and by extension, the wealthy deserve this comfort and are safe from the fate of the poor (Scott, 2010, p. 33)

Institutionally, in eastern Kentucky, community coalitions have been instituted to address not only cancer prevention, but drug abuse (Operation UNITE), and environmental pollution (PRIDE). All three organizations frame their respective issues in terms of personal responsibility, shifting responsibility away from social and structural explanations and promoting individual solutions to community issues. When seen in from broad light of “identity of the region” (Paasi, 2003) there emerges a governance theme that uses “grassroots” and “community-based” in a regional discourse that redefines social problems in individual terms and attempts to make an ideological shift that acclimates populations to reduced social services and a minimal social safety net, to continuous ineffectual government regulation, and to a lack of accountability for industries and institutions in the region to the populations they serve. Health promotion rituals become one of several kinds of institutionally legitimated forms of “civic participation” that transforms “matter out of place” (people engaging in failures of will) into accountable “citizen-consumers”.

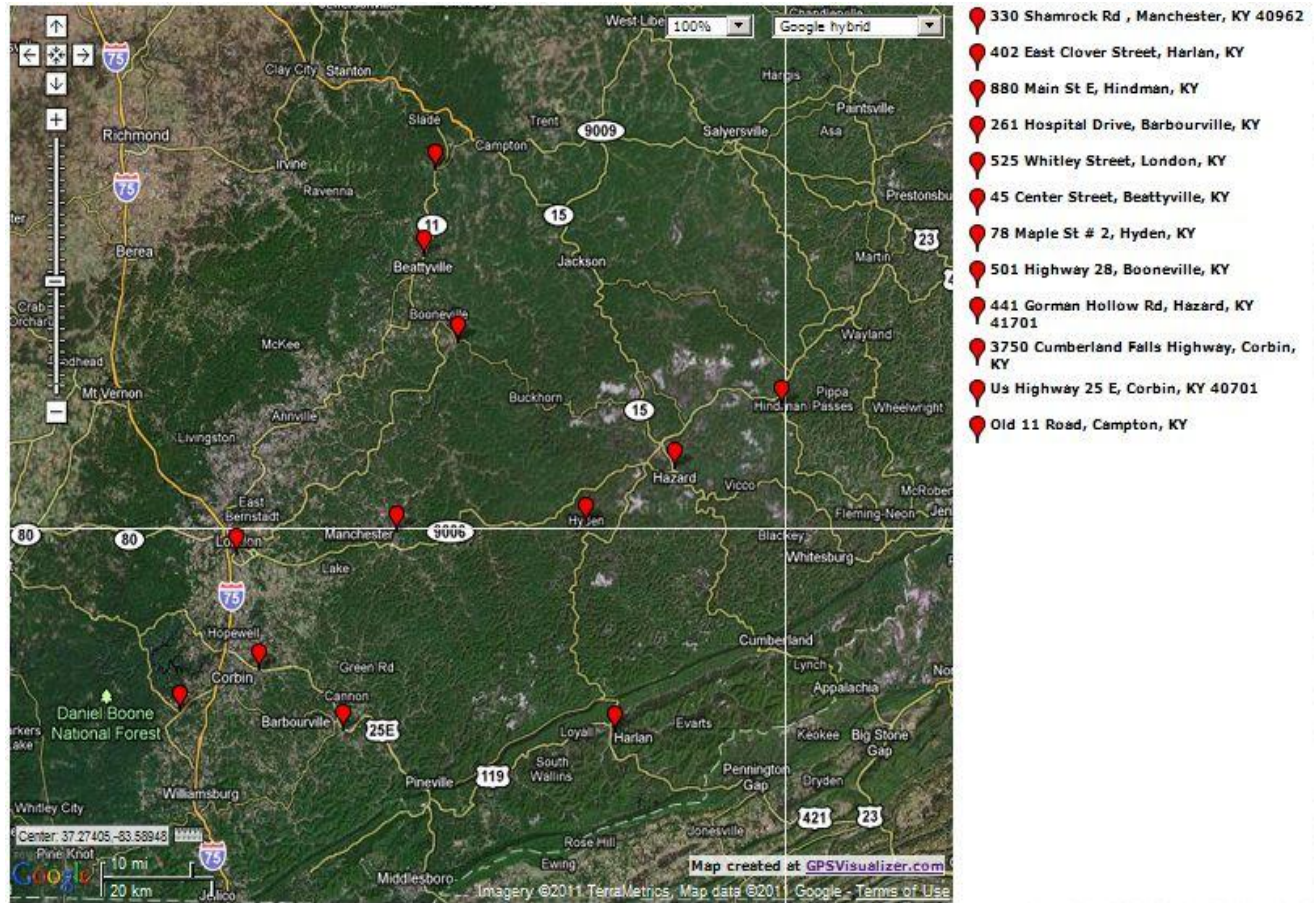
The current cancer prevention coalitions, then, exist as an instantiation of the success of a group of institutional actors operating at the national and state levels who have competed to get selected definitions of cancer prevention recognized and accepted. In turn, these actors have accessed and distributed resources to establish and maintain a core infrastructure of organizations to implement the goals of their program of action. As mentioned previously in Chapter One, community-based participatory research methods originating in public health promotions run the risk of profoundly narrowing and

depoliticizing the conceptualization and practice of health promotion (Stevenson and Burke, 1991). For these authors, emphasis on community participation in a research process can come to overshadow other possible forms of possible action, including political mobilization. Consultation at the research stage is not political power and may not give communities the ability to implement the results of research, to use research to gain resources, to overcome barriers to health, or effect social change. As discussed in the previous chapter, coalitions are billed as community partnerships, but KCP's cancer coalitions run the risk of exemplifying "bureaucratic logic in new social movement clothing" (Stevenson and Burke, 1991). By this, I would suggest that the idea that a program is community-based and "grassroots" obfuscates the directionality of programmatic goals in relation to coalitions, mystifying how locating the coalitions in community public health clinics systematically distorts the basis of coalition recruitment. We need to bring the narrow arena of activities that exemplify the "pink ribbon" approach into relation to other, competing arenas in the region to re-introduce the voices that have been excluded as the institutionalization process has limited the "carrying capacity" (Hilgartner & Bosk, 1988) of mainstream cancer prevention discourse to include problems related to the definitions of cancer and cancer prevention as simply a problem of lifestyle and consumer consumption, the possibility of environmental causation behind high rates of cancer in the region, and ways that institutional structure impact who gets recruited to coalitions and what activities appear as common sense responses to local concerns.

Public Health, Coalitions, and the Spatial Division of Labor

As part of the Kentucky Cancer Action Plan project, cancer prevention coalitions are part of the "institutional and distributional projects" (Pred, 1984) of state and regional public health. They have a "spatial division of labor", which, for the most part, is grounded in the county public health clinics in the counties where coalitions exist. **Figure 3: Spatial Distribution of Health Departments as Loci of Coalitions.** Two things are immediately apparent by mapping the place of these clinics in their placement both in or near important local towns in various counties (for the most part, county seat towns in each county) as well along primary roadways that crisscross the locale. Together, the placement of major roadways in relation to local seats of economic power reflect the

Figure 3: Spatial Distribution of Health Departments as Loci of Coalitions



historic relationship of the region to capitalist markets and efforts by local elites to control economic and political power and the impact that those struggles have had on shaping the landscape of the region and creating a continual resistance between the environmental imaginaries of “landed households” in the region and “outsider” imaginaries that have sought allies locally in their efforts to gain control of and exploit local natural resources (Lewis, 1995; Nesbitt, 1997; Nesbitt & Weiner, 2001; Billings & Blee, 2000). Situating health departments near county seat towns is part of a “natural” progression that tends to locate economic and political power near core communities in a county and to understand travel to that community for material, medical, and economic transactions as only “common sense”. Typically, major retail outlets, banking, legal, medical and other services will locate in the county seat town, centering economic and cultural reproduction in and around the county seat, making it the major communication action context (Ball-Rokeach, Kim, & Matei, 2001) for health communication and

decision-making.

Figure 7: Cancer Prevention Coalitions located in County Health Departments in Relation to Mountaintop Removal Sites from Chapter Two represents the health departments in relation to mountaintop removal locations in the region. Nesbitt and Weiner (2001) argue that regional underdevelopment has in large part followed as a consequence of land ownership being concentrated in the hands of private absentee interests who own large tracts of resource rich land and also from large land ownership by the federal government. This ownership pattern has had a tendency to limit settlement and keep population densities in many counties low. Sanford and Troske (2007) found the low level of economic growth in the rural areas of Kentucky, particularly in eastern Kentucky, have been the major inhibitor of progress in Kentucky. This is an interesting finding in light of research by the Mountain Association for Community Development (MACED) on the economic impact of coal production in Kentucky. Coal production has been in decline for some time in the region, and, along with increasing deployment of mechanized mining practices and the rise of Mountaintop Removal Mining, no longer employs significant numbers of miners to produce coal. According to MACED (2009), coal mining provided over 50,000 jobs in Kentucky in 1979, including approximately 36,000 jobs located in the Appalachian eastern Kentucky. By 1992, mining jobs in eastern Kentucky reached levels around 20,000, and had continued to drop. By 2004, there were just above 13,000 employed in mining in Kentucky. Rising global demand for coal recently has increased mining employment only to decline again more recently still due to economic recession. MACED authors argued that temporary booms in employment have not negated the overall downward trend in mining jobs over the last three decades such that mining employment now makes up only one percent of total nonfarm employment in Kentucky.

Even though mining jobs make up a large percentage of employment in these counties, the actual number of mining jobs is still relatively small. Mining accounts for a large retail percentage of county wages not because mining jobs are so numerous, but because other jobs are so scarce. The unemployment rate in Central Appalachia is much higher than the rest of the nation, and eastern Kentucky's unemployment rate is among the highest in Central Appalachia. The percentage of working-age adults who are not employed is far higher than the official unemployment rate, which only counts those who are actively seeking employment. So while coal is a significant employer in some counties, the

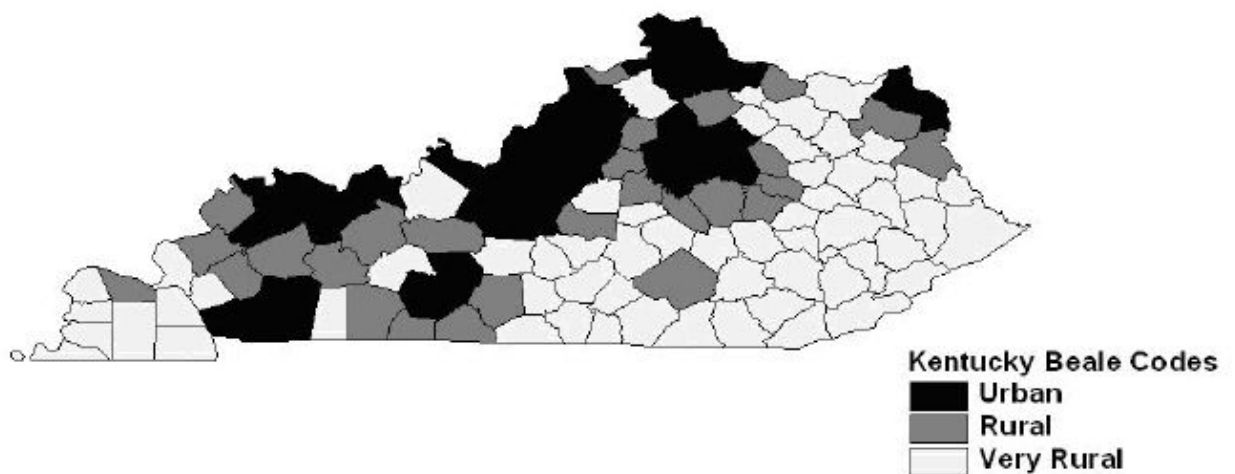
industry only provides jobs for a small fraction of the working age population in those counties (MACED, 2009).

Recent research into regional identity in coal communities (Oberhauser, 1995; Ahern & Hendryx, 2008; Bell & Braun, 2010; Bell & York, 2010; Scott, 2010) has stressed how the economic and gendered identities of Appalachian men and women are shaped by the spatial division of labor that understands industrial and coal-related labor as the domain of bread-winning males, i. e., as “real work”. Retail and business, teaching, and medical labor, to name a few, are considered inferior forms of employment, with retail and medical care being seen as women’s work. Scott (2010) recounts stories from Blair, WV, where the community as a whole was bought out or destroyed to accommodate the local coal company’s needs. Similar conditions have been occurring in eastern Kentucky since the turn of the 20th century, when coal camps were completely abandoned once the coal was mined out. More generally, mining communities have endured a variety of insults to local water and sewage systems, homes and roads related to mining. In 2000, Martin County, KY was flooded with mine sludge and black water as an impoundment pond ruptured and spilled toxic water into valleys below it. Historic communities like Benham and Lynch, KY in Harlan County, KY have lived with constant threats to property and water quality due to coal mining activities in and around Black Mountain in Harlan County (National Trust for Historic Preservation, 2011). Eastern Kentucky is a landscape of two communities, then, made up of the locality of houses and people, but possibly more importantly of a moral community that places “the male worker in a complex position in relation to the dependent members of his household, the state, and the market (Scott, 2010, p. 491)”. The patriarchal position of the male worker as head of the household structures what counts as real work and conceptually limits economic choice in the community.

According to the American Public Health Association (2010), Kentucky has the highest smoking rate in the nation (25.6 percent of the population), the fourth highest obesity rate (32.3 percent of the population), and significant health disparities in this area, as the obesity rate of blacks (42.6 percent) greatly exceeds that of non-Hispanic whites (29.9 percent). Kentucky has the highest rate of deaths from cancer (227.0 deaths per 100,000 people), the second highest rates of high cholesterol (41.6 percent of adults) and

cardiac heart disease (5.9 percent of adults), and the fourth highest rate of diabetes (11.5 percent of adults). The number of preventable hospitalizations is 102.0 per 1,000 Medicare enrollees, which is the second highest rate in the country. The state spends an average of \$46.14 a year on the public health needs of each resident, which is the sixteenth highest level in the nation. Sixteen percent of Kentuckians do not have health insurance, though this number glosses over how being uninsured is distributed differentially based on whether one lives in an urban or rural area in Kentucky.

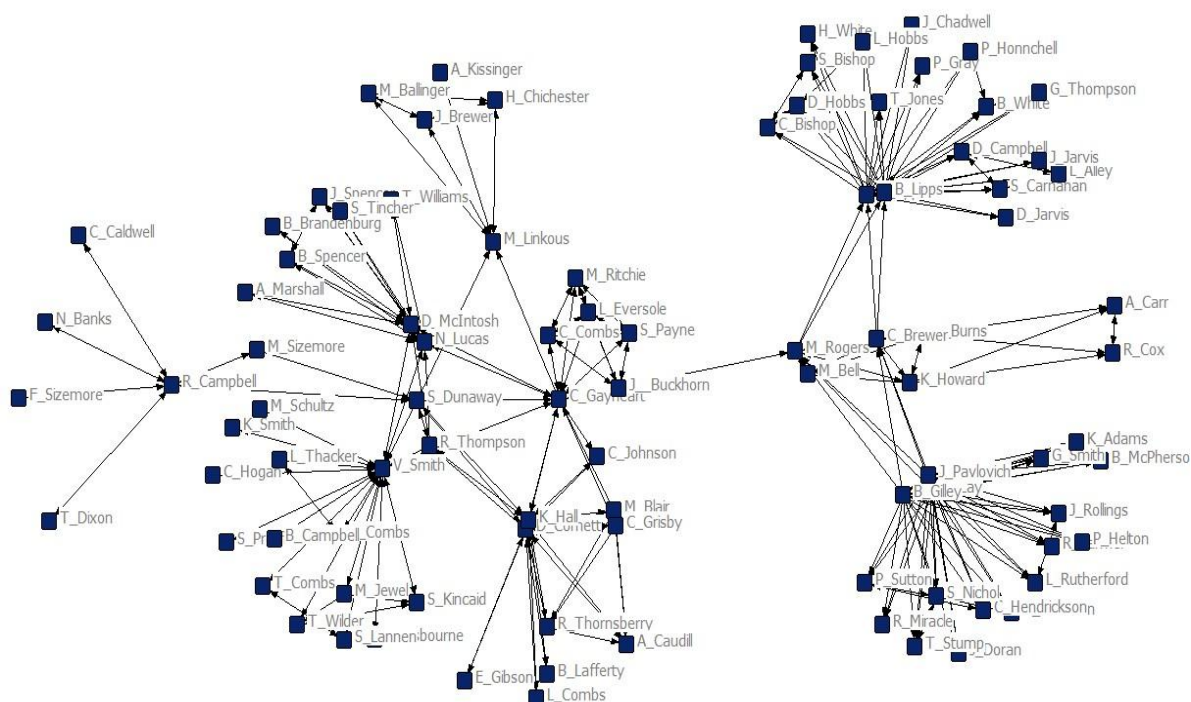
These data do not tell the whole story however. By focusing on central tendencies, rate information hides an uneven urban/rural division in Kentucky (see **Figure 4: Rural/Urban Continuum in Kentucky**) that is exacerbated the concentration on coal production in eastern Kentucky. High rates of uninsured can be found in Eastern and



Adapted from Davis, A. (2009). Kentucky's Urban/Rural Landscape: What is driving the differences in wealth across Kentucky? Kentucky Annual Economic Report. Center for Business and Economic Research. Gatton School of Business and Economics. University of Kentucky, Lexington, KY

South Central Kentucky (See **Figure 5: Percentage of Individuals without Health Insurance**). This high rate of uninsured persons in an area is strongly related to the chronic disease burden in the region. Uninsured individuals do not seek preventative care and only visit a health care provider after they are already ill or in an emergency situation (Davis, 2009). Also, the uninsured often visit public hospitals for non-life threatening issues and thus put a strain on hospital finances when they are unable to pay their bill. The map indicated that some of the highest rates of uninsured are in the counties examined in this study. As mentioned in the previous chapter, all sixteen of the counties

Figure 5: The Coalition Networks of the Kentucky River ADD and the Cumberland Valley ADD

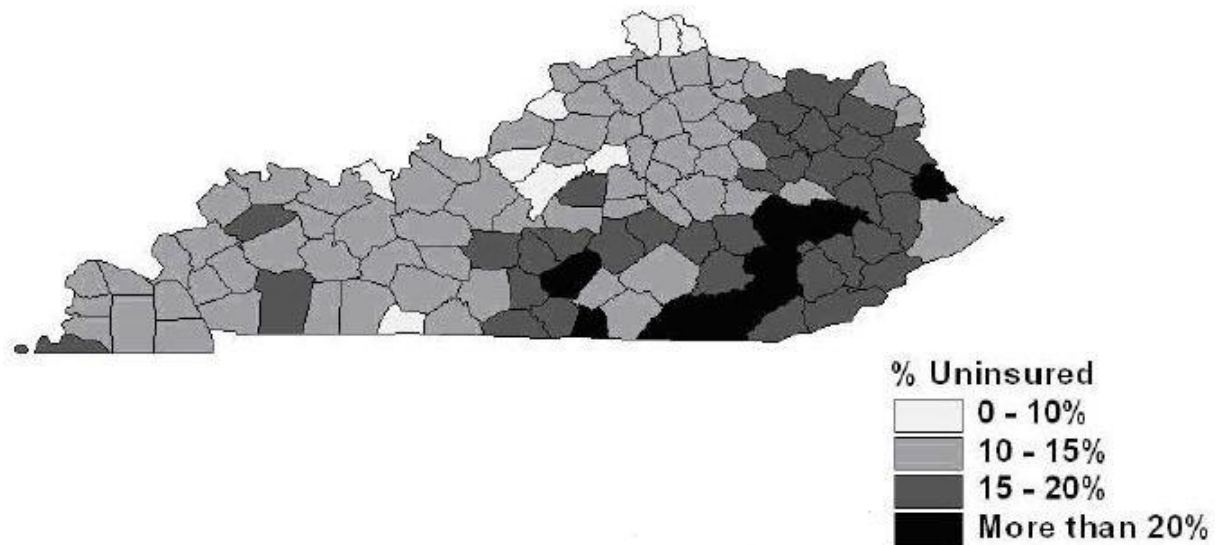


are coal producing counties.

According to Hendryx (2009), people in coal mining communities have a 70 percent increased risk for developing kidney disease; have a 64 percent increased risk for developing chronic obstructive pulmonary disease (COPD) such as emphysema; are 30 percent more likely to report high blood pressure (hypertension). Hospitalization rates in mining communities have been found to be high for a number of conditions:

hospitalization stays for COPD increases 1 percent for every 1,462 tons of coal and hypertension increases 1 percent for every 1,873 tons of coal. The total mortality rates are higher in coal-mining areas compared to other areas of Appalachia and the nation and the incidence of mortality has been consistently higher in coal-mining areas since rates have been collected beginning in 1979 (Hendryx & Ahern, 2009). This pattern would appear to suggest that the high rates of public health expenditures are in at least in part the result of the combination of exposures to negative mining related health risks, combined with high rates of uninsured population in these very same rural counties. **Figure 6: Health Outcomes by County** and **Figure 7: Health Rankings by County** based on county level data from the Robert Wood Johnson Foundation's collaboration with the University of

Figure 6: Percentage of Individuals without Health Insurance*

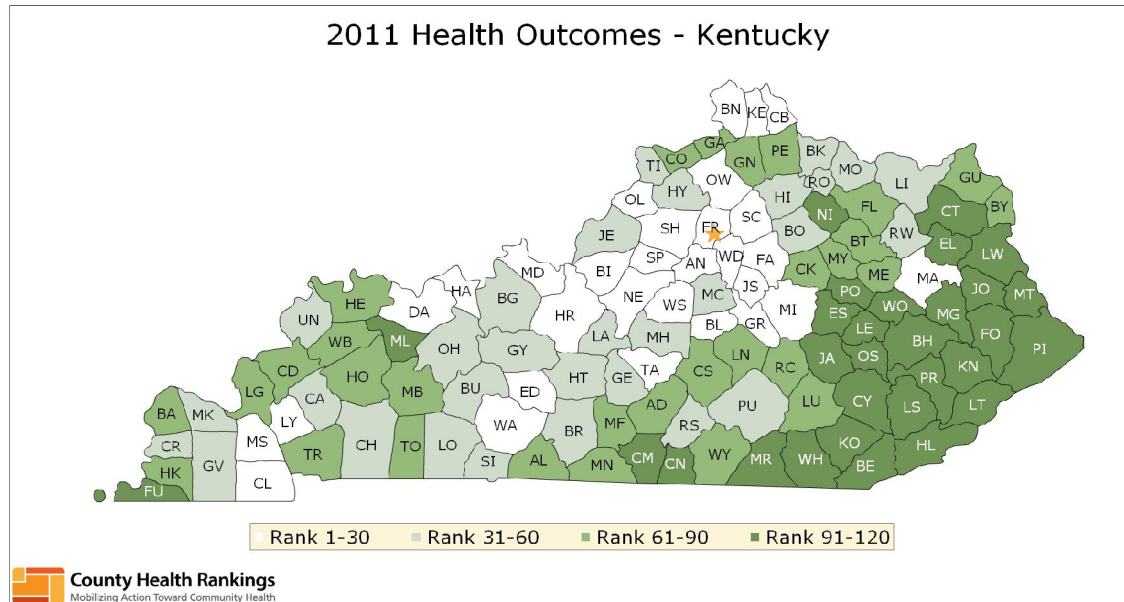


Adapted from Davis, A. (2009). Kentucky's Urban/Rural Landscape: What is driving the differences in wealth across Kentucky? Kentucky Annual Economic Report. Center for Business and Economic Research. Gatton School of Business and Economics. University of Kentucky, Lexington, KY

Wisconsin Population Health Institute to develop health rankings for each state's counties (Peppard, Kindig, Dranger, Jovaag, & Remington 2008). The maps illustrate graphically the ways poor outcomes and health rankings in eastern Kentucky correlated to the urban/rural continuum discussed above, suggesting correlation to the same underdevelopment policies that keep the coal industry in dominance in the region.

Folch-Serra (1990) argues that actors create landscapes through metaphors and comparisons whose outcome is building roads, towns, and cultures. A landscape becomes the repository of polyphony and heteroglossia, a place where "social, historical, and geographical conditions allow different voices to express themselves differently than they would under other conditions." The landscape articulated by the placement of health departments along major roadways and near county seat towns reflects resource allocation decisions that understand the county seat of a county to be the center of economic activity. Health departments base a good percent of their budgets on the distribution of funds by county judge executives and county health boards. The placement also reflects the larger place of public health clinics as agents of enforcement for restaurant cleanliness, the quality of city and county water supplies, monitoring of the

Figure 7: Health Outcomes by County



environmental safety in local public schools, and the health and well-being of low income mothers and their children. It is a historical set of decisions that has placed the impacts of mining and other industrial polluting in the care of state environmental protection agencies and removed them from the custody of public health services, grounding the mystification of mining-related pollutants and their impacts in a fundamental structuring of government institutions, thereby setting up a fundamental displacement in the regional consciousness of the public health community that divorces it from responsibility for speaking out about the long-term impacts of mining and other industrial pollution on the health of eastern Kentucky populations.

An additional displacement of the impact of mining from public health concern is built into how county health departments derive their funding. State funds are distributed through local fiscal courts and local health boards, giving significant leverage to the fiscal courts for controlling local public services, public health, and local economic development projects. County health departments in eastern Kentucky have not traditionally joined the conversation about the impacts of industrial pollution and environmental damage that have been endemic to the region in part because it puts them in the line of direct conflict with fiscal courts and local economic development. Though there have been efforts nationally by public health officials to begin to join this conversation, and public health officials as close as Louisville have begun to engage the

issues of place, environmental quality, and health disparity, the issue appears to remain in the background in coal communities. Bell and York (2010) argue that communities most vulnerable to industrial pollution and environmental destruction are often the communities most dependent on jobs within the polluting industries. Middle class communities even within such counties are geographically and socially removed from the pollution, having the money to move upstream and upwind of contamination and destruction, while blue-collar neighborhoods are often located within close proximity to polluting sites.

In later chapters I will discuss newspaper stories from the Harlan Daily Enterprise concerning the upgrades to local water and sewage systems in the county. In those stories we will see that, even though local officials are at times candid about historic unwillingness of coal operators to build adequate sewage systems in coal camp towns, and officials are equally candid about the fact that mining practices damage local water and sewage systems, city and county government are inclined to reduce repairs and upgrades to a technocratic decision-making process rather than hold coal companies liable for ongoing damage they do to public works systems. Additionally, local health departments are viewed only as agents of enforcement to support technocratic decisions to build new systems and make hook-up to those systems as compulsory, rather than as advocates for clean water and adequate public sanitation. These stories reinforce the idea that displacements between state level agencies as well as at the level of county level leave working-class neighborhoods suspicious of outside intervention, which typically as often as not works counter to their interests as much as with them.

Regionalized Action and the Shape of Sustained Participation in Coalition Activities

In a series of papers, Florence Passey (Passy & Giugni, 2000; Passy & Giugni, 2001; Passey, 2002) has outlined the place of social networks in sustaining commitment to collective action. She identifies three functions that networks perform: 1) Socialization function – networks function to promote identification with certain political issues, such that social networks forms the initial condition for the establishment of the framing process that occurs between an individual and a social movement; 2) Structural-connection function – functions through the ways that social ties become the major channels through which potential activists are connected with an opportunity for

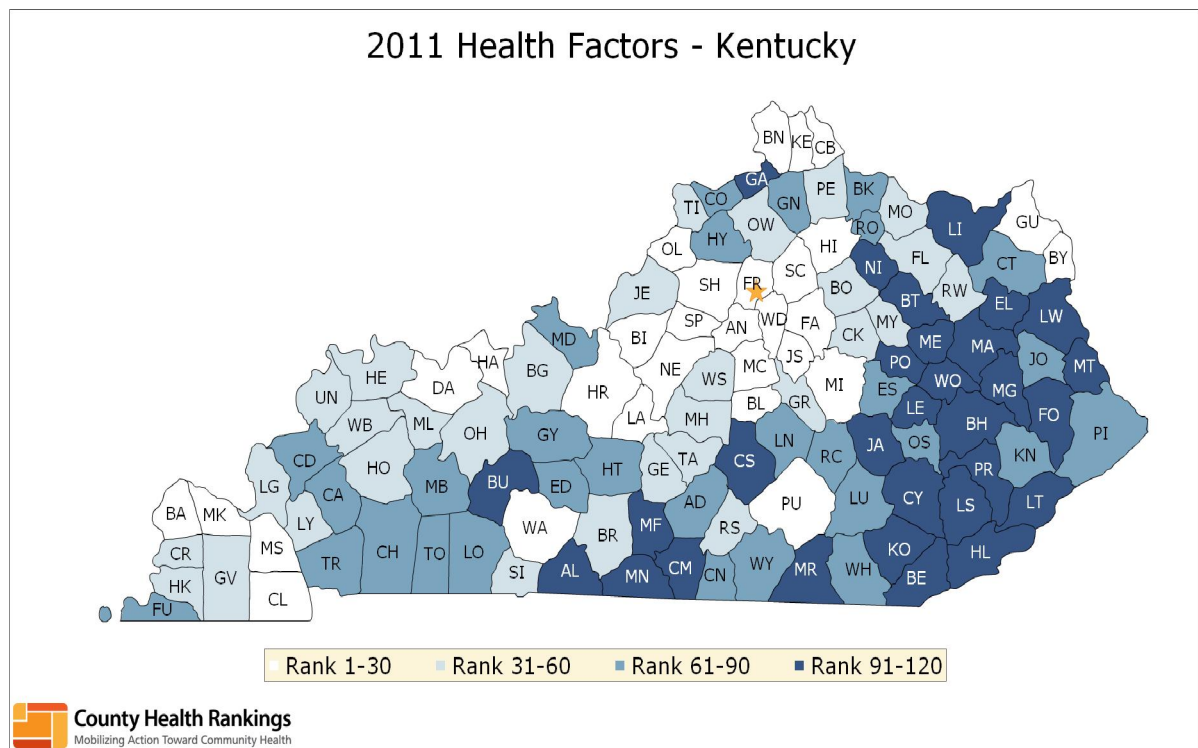
participation, while networks also play a mediatory role by connecting prospective participants to an opportunity for mobilization, thus enabling them to convert their political consciousness into action; and 3) Decision-shaping function – this function involves the crucial nexus between individual decisions and social relations including the decision to join collective action as influenced by the action of other participants. The Kentucky Cancer Action Plan and the Kentucky Women’s Cancer Screening Program shape the third function. It is the first and second of these functions that I have been addressing so far in this paper.

With this in mind, we can examine the overall shape of the eleven county networks. In **Figure 8: The Coalition Networks of the Kentucky River ADD and the Cumberland Valley ADD**, the coalitions of the Kentucky River ADD are located on the left and the coalitions of the Cumberland Valley ADD are on the right. Each cluster is tied through connections to the KCP coordinators and their ties to the respective regional health department contacts and to the American Cancer Society representatives for the area. The Tri-County Coalition from Knox, Laurel, and Whitley Counties mentioned in the previous chapter is located in the lower right corner. The subnetworks made up of individual coalitions often are variations of star networks with either one or two central actors who typically operate as coalition officers and carry out much of the ongoing business of the coalition and a host of links tying them to others in the network in a characteristically starlike shape.

In this star configuration, the coalition chairperson and secretary position, along with the coordinators and regional health department contacts, act as “hubs” around which there is a “preferential attachment” by others in the network (Barabási & Bonabeau, 2003). Theoretically, in social networks, the preferential attachment process is any of a class of processes in which some quantity of wealth or credit or other resource is distributed among a number of individuals according to how much they already have. Those who are already resource rich receive more than those who are not. In relation to cancer prevention coalitions, the quantity which acts as a basis for preferential attachment is related to the ability to access and distribute information and material resources, as well as to control the flow of institutional power to make decisions.

The coalition networks appear to be “scale-free” (Barabási & Bonabeau, 2003). Scale-

Figure 8: Health Rankings by County



free networks have a high number of ties with an ingoing and outgoing flow that greatly exceeds the average flow of other nodes in the network. These high-flow nodes, or "hubs", serve specific purposes in their networks, although this depends greatly on the domain. In the coalitions, these hubs are essential to the flow of information about current health promotion activities at the state and federal level. The coordinators from KCP make available "incentives" (small items given away during Ladies Day and other promotional activities), cancer prevention flyers, updates on the availability of federal and state grant money, and other information or resources. The scale-free property makes this kind of network "robust" to failure. Major hubs (in the coalitions, these are the KCP coordinators) are closely followed by smaller ones (like the American Cancer Society regional representative and regional health department contacts). These nodes, in turn, are followed by other nodes with an even smaller degree (typically the coalition chair, treasurer, and secretary) and so on. This hierarchy makes coalitions "tolerant" of one person leaving the coalition. If failures occur at random and the vast majority of nodes are those with small degree, the likelihood that a hub would be affected is almost

negligible. Even if a member leaves (called a “hub failure”), the network will generally not lose its connectedness, due to the remaining hubs. This tends to make the organizational position of actors involved with the coalition more important than the person occupying the position. Taking a few persons out of the network can experience technically result in the network isolated actors for a period until new members can be found. It also tends to minimize the emotional commitment members might feel to the coalition, given their connection may be built solely on organizational position. The hub structure, then, is both a strength and a weakness for such a scale-free structure.

How Network Structure Impacts Coalitions as Vehicle for Democracy

The star structure of coalition ties overcomes the problem discussed previously in terms of establishing a link between state-level activities related to cancer prevention including dissemination of research findings and health promotion recommendations and programs from academic circles and state and federal governments to local communities. Coordinators from KCP regularly attend coalition meetings in many of the counties. They provide help to health departments in implementing a coalition, offer informational and moral support to coalition members, distribute literature and research findings, and make “incentives” available for coalitions to deploy during various promotional activities throughout the year. The preferential attachment that connects coalition officers to regional health departments, KCP, and ACS are grounded in institutional role structures and hence are generally stable, at least in terms of the roles that make them up. Only one coalition, in Clay County, Kentucky, is not structured by the same institutional hierarchies. In that county, a local church took up sponsorship of the coalition and its membership does include a liaison to the health department, but is actually the only coalition that is genuinely constructed primarily outside public health’s institutional structures.

Stability of information transfer through a star network structure is different than the kind of stability achieved through committed ties one would expect to be part of an organic social movement. According to Passey and Giugni (2001) actors who join social movements and become committed to the cause over time form bonds with a few important persons, often a faculty member at school, or some other important persons or persons who establish a lasting bond to the recruit and who serve as an important

structural connection between the recruit's lifeworld and the social movement. As the recruit becomes progressively more active over time, they are socialized into the movement as part of their lifestyle and this socialization leads to adaptations of schedule and resource use to incorporate the movements ideas, attitudes, language, and beliefs into the person's lifeworld. Most of the coalition members I talked with were not significantly involved with cancer prevention prior to their current job placement and they became involved only because their job position made it possible for them to take part in the coalitions. Few of the coalition members were nurses or clinicians actually delivering screening services, but were instead health educators or support staff who held responsible positions within local health departments or at the local hospitals. Others were educators in the local county extension agency. Some coalition members were community members; the mix in a particular county appeared to be related to the additional types of community groups in the county, whether there were Women's Clubs, Retired Teachers Associations, or Senior Citizen's Groups, etc. This last group of members were most like the committed persons described by Passey and Giugni (2001), having no real institutional impetus for their involvement beyond personal experience with cancer and cancer screening through friends and family.

Many of the people I talked to included experience with a family member who had had cancer, but with the risk of having cancer in the US approximately in 2 for men and 1 in 3 for women, it would appear that is more unlikely that someone has had a family member or a friend have cancer than not (National Cancer Institute, 2010). It is unclear that this structural connection provides strong motivation for many to become regularly involved in coalition activities. Only a few coalition members from across the sixteen counties were actually survivors themselves. Given that "cancer survivor" is not an identity that persons who experience the disease are likely to readily claim (), this too, does not appear to be the strongest motivator for most coalition members to remain active over time. In the long run, the strongest indicator of involvement over time appears to be institutional role. The primary source of socialization into coalition activities is grounded in professional education and employment in cancer-related medicine. This pattern has the overall effect of sustaining coalitions as top-down structures mainly shaped by institutional hierarchies and expert discourses as opposed to dialogue from the

phenomenological experiences of local community members. The narrow goal focus utilized by coalitions is in large part set by the narrow constraints of the institutional structures in which they are embedded, making them very unlikely to challenge community power structures that support the patriarchal basis of status and material inequity that is the source of health disparity in the region.

Coalitions become a means to assure a small portion of the health subsidies that come into the region are set aside for cancer prevention activities. In this sense they serve as of a tool to open the region up to the health care market. This effect is exacerbated by the push to have coalitions focus on fund raising and grant writing by establishing coalitions as 501©3 organizations, ignoring the personhood of community members in favor of a modified form of corporate personhood that can be held accountable for funds raised and made to validate the productive and efficient behaviors of coalition members, particularly those employed by medical and public service institutions.

The broad logic of my argument can be summarized in the following manner. Preservation of the mining industry in the region has created the conditions in the region Scott (2010) describes as an energy “sacrifice zone”. The “sacrifice zone” roughly correlates with parts of the urban/rural split in the landscape of Kentucky and, thus, correlates with many economic and public health deficiencies that characterize the rural/urban differences in the state (Billings, 2000; Nesbitt and Weiner, 2001; Sanford & Troske, 2007; Davis, 2009; MACED, 2009; Hendryx & Ahern, 2009; Hendryx, 2009). Research on the impact of the mining industry in the region points to significant negative public health effects of mining on the region, including toxic exposures that are likely elevating cancer rates.

Decline in coal production and the accompanying job declines has created a legitimization crisis for the coal industry (Bell & York, 2010; Bell & Braun, 2010). The ideological campaigns to rewrite the region’s economic identity as pro-coal have heightened status inequities grounded in patriarchy that represents male wage earners as doing “real work” while marginalizing various forms of service labor. The coal industry’s ideological campaign resonates with broader trends in neoliberal governance and economic policy which posits a need for austerity of social security in the face of declining public funding. It also utilizes discourses of “accountability”, “efficiency”, and

“productivity” as part of a process that gradually frames and reframes failures of will as either medically ill or criminally deviant. These discourses mark status differences between the deserving and undeserving, pressuring cancer prevention coalitions towards fund raising and grant writing to make up for short falls in the cancer prevention safety net. It also pressures those coalitions who do engage in fundraising to heavily monitor who receives funds.

All but one of the coalitions are heavily organized by institutional hierarchies within public health and the health care institutions. Organizational structuring conditions the typical kinds lifeworld based structural and socializing ties that would make up commitments to a social movement. The embeddedness in institutional hierarchies establishes a kind of preferential attachment to certain institutionally defined actors which give the coalitions stability, but also set limits on the kinds of activities they engage in. Because most coalitions are grounded in local public health clinics dependent on the good will of county fiscal courts and public health boards for funds, it becomes unlikely they will risk stepping out of the top-down goal setting of state and federal cancer institutions to speak to the community power elite whom support health disparities in the community.

Chapter Five: Colorectal Cancer Screening Among 49 Appalachian Eastern Kentucky Primary Care Practices: Controlling for Structural Aspects of Space*

Introduction

In chapters two and three I spent considerable time discussing how coalitions are part of the institutionalization of cancer early detection and screening activism. This institutionalization process involves a kind of “regionalized social action” that establishes cancer prevention activities as part of the everyday routine of the healthcare social world in eastern Kentucky. The various networks established and maintained by the coalitions are an initial part of the production of cancer prevention medicine services, recruiting “risky subjects” (Klawiter, 2008) through practices to promote awareness of cancer risk and encourage community members to buy into the sense of duty to community and familial ties.

Cancer screening referral networks can be thought of as a middle stage in the production process where potential subjects must take the action step to actually be screened. The number of community members who actually get screened constitutes an important benchmark for the success of promotional activities. Additionally, either continued returns for yearly screenings or movement into the treatment phase of cancer medicine constitute the endpoint of the process. Coalition members may be employed in facilities that do screenings, but the coalitions themselves are not responsible themselves for conducting screenings. I include this chapter as a way to illustrate how spatial and organizational features of the actual screening process establish a constraint on what can be accomplished by coalitions. At some point, awareness building and fund raising must translate into increased levels screening among the target population, though there may be any number of conditions outside the control of the coalitions to make this happen.

Cancer screening referral initiates a kind of “package delivery process” (Borgatti, 2005) in which a medical practice sends a patient to fixed destinations for screenings (usually a local hospital which has the necessary laboratory capabilities). I assume one is likely that travel to such a destination is along the shortest route possible, since colonoscopy is a time consuming process and it is very likely a patient would want to minimize time spent traveling by choosing the most direct route to a testing location. In a region that is mostly rural like the one in this study, travel can occur over a variety of

road types including two-lane rural routes as well as four-lane interstates or parkways. Locations central to the region would be advantageous for ease of access. The severe shortages of providers, underfinanced services, and systems in transition mentioned above would increase the “hassle factor” of following through on a recommendation for colonoscopy and likely set a limit on the distance individuals might be willing to travel to follow through on a recommendation.

In this paper I use a normalized social network measure of closeness centrality to explore relationships among percentages of colorectal cancer screening recommendations by a network of regional medical practices, relative locations of those practices within eastern Kentucky, and the linear distance between the practices. Closeness centrality can be thought of as an index of the expected time of arrival of something flowing through a network (Borgatti & Everett, 1995; Borgatti, 2005). In the context of recommendations for colorectal cancer screening, closeness centrality can be interpreted then as a proxy for local common sense understandings about how long it takes for someone or something to get from one site to another within the region, and it also points to how these common sense explanations affect decisions to refer as a possible mechanism for further investigation in later program evaluation research. In the next section, I attempt to organize these factors in relation to social networks, particularly as a function of closeness centrality.

Colorectal Cancer Screening in Appalachian Kentucky

Behringer and Friedell (2006) point out that most of the Appalachian region of the United States is rural and that this fact can account for many of the difficulties developing a set of cancer care services in the region that meet the needs of its residents. Ten of the thirteen Appalachian states have counties within the Appalachian Regional Commission’s designated Appalachian counties that have population densities below the state average. Eighteen of twenty-four Appalachian Kentucky counties included in this study’s sample have population densities below the state average. Forty-six of the forty-nine practices in this study’s sample fit the classification as being in “rural” communities and only three as located in “urban” communities under the Rural Urban Commuting Areas (RUCA) 1.1 system; forty-two practices (85.7%) are located in communities considered small- or

isolated small-town focused in terms of their commuting patterns within the same system of classification. Also, thirty-one of the forty-nine practices (63.3%) are ranked in the bottom half counties rated in the Kentucky Medical Institute's (2007) Health of Kentucky study, with twelve practices (24.5%) ranked in the bottom twenty counties in terms of their overall health status. In sum, the sample used is representative of small town, low-income, and geographically Appalachian communities Behringer and Friedell (2006) suggest are likely to experience difficulties developing cancer care services.

According to an American Cancer Society survey, a frequent reason for low screening rates is "it was not recommended by my doctor" (Winawer, 2001). Yet, the health care system that in Appalachia has severe shortages of providers, underfinanced services, and systems in transition (Dignan, 2007). In addition, poverty, disability, underemployment, and unemployment hinder the ability of Appalachian residents to receive preventive services. Overall, 68.1% of counties in the U.S. have a designated health professional shortage, whereas 79.6% of counties in the Appalachian region of Kentucky are so designated. Characteristics of patients from Appalachian Kentucky strongly associated with screening rates in previous research include low screening rates among individuals who are 50-64 years old or individuals with low socioeconomic status. Lower incomes, little or no health care coverage, and fewer years of education are also common among Appalachian populations. Rural populations generally tend to be poorer than urban populations and populations in eastern Kentucky are no different. Many of the problems associated with poverty are magnified in rural areas because travel costs and lack of convenient access to services complicate both acute and preventive care. On the other hand, while doing interviews with cancer prevention coalitions in the region, I discovered that it was not uncommon for those with higher incomes, stable employment, medical insurance, and reliable transportation to drive from various parts of eastern Kentucky to Lexington, KY for cancer care, even if there was a local hospital doing similar care within a more convenient driving distance.

Additional explanations that may account for the under-utilization of colorectal cancer screening include several physician characteristics: (1) physicians may inadequately promote colorectal cancer screening because of lack of knowledge or understanding of the benefits of screening; (2) physicians may not recommend screening unless warranted

by sufficient patient risk (even though 75% of colorectal cancers occur in patients at average risk); (3) physicians may believe the benefits of screening are still unproven; and (4) competing demands concerning co-morbid conditions such as diabetes and heart disease place colorectal cancer screening lower on a list of priorities (Vernon, 1995; Cooper, Yuan, Veri, Rimm & Stange, 1999; Gazelle, 2001). I would suggest that many physicians fail to make referrals when they know that patients have complicating factors that make travel for screening difficult, not the least of which are difficulties arranging transportation to screenings, having money for the expenses of making the trip (i.e., money for food, lodging, etc.), or getting time off from work to make a trip perceived as long and expensive.

Conceptualizing Screening Recommendations in Terms of Closeness Centrality

Centrality is a structural attribute of nodes in a network. It is not so much an attribute of the actors themselves, but of their structural position in the network (Borgatti, 2008). It is a measure of the contribution of network position to the importance, influence, prominence of an actor in a network. Measures of centrality are an index of an actor's potential for importance, influence, or prominence based on network position alone. A facility with the necessary technology for accomplishing a colonoscopy would gain prominence in a regional setting, particularly rural a setting where services are limited. By the same token, if distance to and from a centralized location are too great, someone seeking services may choose not to follow through on a recommendation, or, possibly, practitioners may decide not to make referrals to some patients if they believe it is unlikely or unrealistic for a patient to travel a great distance due to the cost and inconvenience of making a trip.

Closeness centrality, as I have said, can be understood as an index of the expected time of arrival of something flowing through a network (Borgatti & Everett, 1995; Borgatti, 2005), and thus serves as a useful measure for investigating recommendations for cancer screening in a rural region. To begin conceptualizing practitioner recommendations for colonoscopy as initiating a flow process through a referral network, it is first appropriate to ask, what "flows" from that recommendation for colonoscopy? In part, we can see that 1) patients move from the referring practice to the screening site; 2) notice of the referral should be transferred from the physician to the screening site, and 3)

Figure 1: Properties of Closeness Centrality and Its Application to the Current Study

Centrality Property	Freeman Closeness	Current Data Set
<i>Walk Type</i>	Geodesic	Linear distances among 49 practices
Walk Property	Length of walk	Ranged from 5.706 miles to 155.311 miles
Walk Position	Radial	Emanating from each practice to all other practices in the sample
Summary Type	Mean distance of a node to other nodes	Used the normalized version of centrality such that large value means that the node is more central.

all or part of the patient's chart is transferred. What flows back from the completed screening includes a patient who expects to hear about screening results, as well as some form of documentation of what those results actually are. In both cases, the flow process assumes promised payment for services exchanged between the provider and patient as well as between service providers. Reimbursement, whether through insurance plans, from out-of-pocket-payment, or through entitlement programs, involves different time lags that may or may not delay payment to providers.

The data gathered from physicians and their practices utilized in this study did not originally include descriptive data about the processes involved with making a referral and returning screening results. This is unfortunate because it would allow us to understand the kinds of constraints each practice experiences in terms of roadway use, reliance on mail versus electronic record transfer and other transport issues that are related to its relative location in the region. Also data would be available about the extent to which payment is made as individual out-of-pocket payments, through insurance reimbursement, or through entitlement plans such as Medicare or Medicaid.

Still, colonoscopy recommendation is a kind of “package delivery” that involves at least three units (patient, referral notice, and record) that begins with a service provider discussing colorectal cancer issues with a patient. The activities involved in “colorectal cancer screening practices” may be carried out by several practice employees other than the physician, making screening practices a kind of distributed process, situated in

particular practice settings. The documented colorectal cancer screening recommendation recorded and counted as part of this study's chart review process is likely a proxy for the more generally distributed, situated set of practices. Recommendations for screening involve specific trajectories from the site of recommendation to a location where the screening will take place. The use of linear distances between practices in this study means that each practice is located at the center of its own radial network, spreading out across the region by shortest path to each other practice to predict the extent to which distance impacts recommendation percentages at the practice level.

Following Borgatti and Everett (2006), the use of closeness centrality restricts the type of tie of interest to a geodesic distance, the primary property of which is length. In this study, ties are understood to emanate from practices, as opposed to traveling through them, as one would expect if we were interested in the density of ties as opposed to their centrality. Closeness ties are summarized by calculating the mean distance of one node to other nodes in the network. I assume that such a measure is a proxy for the common sense notions that people entertain when they consider how long it takes to travel in the region to a known destination by the shortest path available. Though distance is used here, it is distance "as the crow flies," and is thus a proxy for a measure of time of travel more than the actual distances measured here. Because of this, I not only demonstrate that the distances between practices result in a statistically significant association to percentage of colorectal cancer screenings for a given practice, but I also calculate closeness centrality for models connected by various path lengths to identify the range of distances and their resulting closeness centrality measures. I then examine how the model fits in relation to controls for relative location in relation to area development district membership and adjacency to major road ways. Finally, I convert the maximum distance of effect to a travel time measure based on road time to estimate the maximum time a patient might be expected to travel to follow up on a recommendation.

Study Sample and Data

The medical practices involved in the sample were recruited from the 51 counties in Appalachian Kentucky. A comprehensive list of all primary care physicians in the area was originally developed by review of the medical licensure database, but was found to be inadequate for recruitment purposes. Eventually practices were recruited through the

Area Health Education Councils (AHEC) in the region. Area Health Education Councils have been established around Kentucky to aid medically-trained students find internships in practices across the state. AHEC personnel involved with the study from the three AHEC regions in eastern Kentucky were able to recruit a number of practices, forty-three practices (87.8 %) already acting as AHEC preceptors, and six practices (12.2 %) not serving as AHEC preceptors.

Originally the referral data was drawn from a random sample of practices from the fifty-one Appalachian counties in eastern Kentucky. The sample became a snowball sample based on who AHEC personnel were able to recruit to describe their knowledge and referral practices in the AHEC regions of eastern Kentucky. Telephone calls were made to the practices approximately 10 working days after the invitations were mailed to assess the level of interest in the project and to secure an initial agreement to learn more about the project. The final sample included 66 practices from the three AHEC regions in eastern Kentucky, with 49 practices completing chart reviews and providing referral rate data (Chart reviews included 3033 cases).

The Transtheoretical model (TTM) (Prochaska & DiClemente, 1982; Main, Cohen & DiClemente, 1995) and an assessment instrument designed to assess physician “readiness to change” was intended to examine physician interest in improving screening practices. It posits six stages individuals move through as they make changes in their behavior. Referral for a screening may be the event that moves a person from a state of ignorance about a potential health problem (called the “precontemplation” stage) into a phase whereby they begin getting ready to change (“contemplation” in TTM terms). Seeking screening as well as translating health behavior change recommendations into personal terms demonstrates that one is becoming ready to change (the “preparation” stage), while acting on the change recommendations, particularly in light of screening results, is considered part of the “action phase” of the change process. The last phase of the TTM model, “maintenance”, could include continued efforts to maintain one’s initial health behavior changes as well as yearly returns for more screenings.

The data set I used here was originally intended to assess whether or not physicians were ready to change existing practices in their organizations to allow for making more colorectal cancer screenings. I assumed that physicians experienced desire to act along

recommended lines for colonoscopy, that they experience an intellectual willingness to agree that that referrals for colonoscopy are a good idea, but, due to cultural understandings, do not make recommendations to those who are “obviously” not going to comply with the recommendation. These are the patients mentioned above for whom it is unlikely or unrealistic to travel a great distance due to the cost and inconvenience of making a trip. What was of interest in the original use of TTM was to test whether the apparent national consensus supporting use of colorectal cancer screening as a tool for prevention and early detection actually translated into coherent practice at the local level, or if concerns and barriers that interfere with implementation were more salient. Efforts to establish a statistical association between assessment results and chart review data failed to be useful using OLS regression. So did an alternative effort to use the assessment simply as a measure of cultural consensus about attitudes toward making practice improvements (Romney, Weller, & Batchelder, 1988; Smith, et al, 2004).

My plan, then, became to treat the 2-mode table of data, Practice-by-Referral Rates, as relational matrix. This allowed me to also develop a distance matrix that included all of the practices and linear distances between them. In doing so, I effectively created a two networks of relations between practices, one based in on the strength of referral rates and the second based on linear distances between practices. The two networks then could be analyzed in relation to each other using hypothesis testing models from social network analysis. For the purposes of this study, I employed Double Dekker Semi-Partialling Quadratic Assignment Procedure (QAP) regression (Dekker, Krackhardt, & Snijders, 2003b). Initially I developed matrices based on relative locations in one of seven area development districts and along one of six major road ways that crisscross the region as spatial control variables that were used throughout the paper. **Table 1** reports the R^2 , adjusted R^2 , and significance values for the three models used. Efforts were also made to use county population, area, population density, and primary care physician to population ratio as independent variables, but those efforts failed as well, all the results are not included.

Methodology

Chart reviews were conducted for 3033 cases across the forty-nine practices by staff at the Cancer Prevention and Research Center at the University of Kentucky. As discussed

Table 1: Initial Model Fit Using Assessment Instruments

Independent Variable(s)	R²	Adjusted R²	Significance
Readiness & Consensus	0.248	0.243	0.060 & 0.103
Readiness	0.235	0.231	0.068
Consensus	0.224	0.224	0.107

in the previous section, recommendations for colonoscopy establish a kind of “package delivery” problem between the practice and referral source and distance between practices becomes a possible independent variable for investigation.. The dependent variable in this study is percentage of colonoscopies recommended by each of the forty-nine primary care practices included in the sample. The percentages were derived from a sample of charts from each of the practices. The vector of percentages was converted to a products matrix via UCINET.

Control variables (**Figure 2**) involved two important classes of variables related to structuring place in the region: area development district location and adjacency to major roadways. Matrices were developed for the seven Area Development Districts (ADD) and six sets of major roadways that criss-cross the region in question. The matrices were partitioned as categorical variables marking a practice either in or not in a particular ADD or along or not along a particular road way. The categories were each mutually exclusive so that no practice could be in more than one ADD or along more than one roadway.

ADDs make sense as a basic organizer of place in Kentucky because they strongly influence how the built environment will be structured by helping to channel funds through the district for various development projects. ADDS affect housing for low income populations, for instance, through their partnerships with the Kentucky Housing Corporation, the organization that is responsible for helping persons with low incomes achieve affordable housing solutions in Kentucky. In relation to healthcare, ADDs help secure funding for many programs for Seniors in Kentucky, they provide funding across the state to support emergency and transitional shelters for displaced populations, and in relation to cancer prevention and control, are important partners with the Kentucky Cancer Consortium, the organization which supports comprehensive cancer control programming across the state.

Two major interstates cut through the region in question, Interstate 64 and Interstate

Figure 2: Space/Place Paradigm

Space/Place	Relational	Attribute
Relative Location	Distances	RUCA 1.1 codes Rural vs. Urban categorization Metro vs. Non-Metro categorization
Bounded Space	Counties Cities	% Below Poverty % Over 65 % Uninsured Crude Colorectal Cancer Rate Smoking Prevalence Obesity Prevalence
Place	Area Development Districts Area Health Education Councils KY Primary Care Association Hospital or Corporate Affiliation	Competence Readiness (Perceived Need for Change) Training Size Practice Type Gender

75. I-64 runs east-west, while I-75 basically runs north-south through the region. Routes 25 and 119 essentially run east-west at the southern end of the region. Routes 27 and 150 run north-south on the western edge of the region, while Route 68 in the northern part of the region and the “middle routes” (Route 460 and the Bluegrass Parkway) in the center of the region cut across the counties on a northwest-southeast trajectory. Proximity to these roadways was treated as a binary vector in the same manner as ADD membership and square matrices for each roadway were generated as well. Together, the ADDS and roadways constituted a set of control variables which could be used in non-parametric regression models to explore associations to relative location in the region.

As mentioned in the previous section, I ran multiple models using Double Dekker Semi-Partialling Quadratic Assignment Procedure (QAP) regression to examine the associations among variables. QAP procedures were initially developed to address issues of autocorrelation in cancer cluster data (Mantel, 1967) and have since been applied in a number of disciplines (Hubert, 1985; Hubert, 1987; Oden & Sokal, 1992; Legrande, 2000). QAP algorithms are non-parametric statistical tests that basically proceed in two steps (Borgatti, Everett, & Freeman, 2002). First, the algorithm performs a standard multiple regression across corresponding cells of the dependent and independent

matrices. The algorithm then randomly permutes rows and columns of the dependent matrix, re-computing the regression, and saving the r-square and coefficients values. Repeated permutations of this second step are used to estimate standard errors for the statistics of interest. For each coefficient, the program counts the proportion of random permutations that yielded a coefficient as extreme as the one computed in step 1. The variables in the regression have to be one-mode, two-way matrices, and, as stated above, conversion to these matrices from vector form are calculated via the UCINET software.

QAP regressions solve two problems for this data set. First, because QAP models utilize a non-parametric permutation test, they solve the problem of spuriousness of association that is possible in a small case data set like the one used in this study (Krackhardt, 1987). All the models in this study were initially tested at 2000 permutations, then retested at 3000 and 5000 permutations. Results are reported from the 5000 permutation run. Secondly, since data were drawn from a snowball sample as opposed to a random sample and gathered within a relatively small geographic area, it is likely that multicollinearity is a problem. Double Dekker Semi-Partialling Quadratic Assignment Procedure (QAP) Regression has been shown to be superior in cases where network autocorrelation and collinearity are possibly problems (Dekker, Krackhardt, & Snijders, 2003a).

Initially, values from the readiness to change assessment scores and a ‘consensus analysis’ (Romney, Weller, & Batchelder, 1988; Smith, et al, 2004) of the same instrument responses were converted from vectors to matrices and used in a series of QAP regressions. The two variables allowed for the possibility that individual level variables related to service provider attitudes were most relevant to the percentage of recommendation made by a practice. Models using readiness and consensus, readiness alone, and consensus alone were run (See **Table 1** above). When none of the models yielded statistically significant association, they were dropped all together and a model using distances between practices was developed. Failure of these variables to account for much of what was going on with recommendations appeared indicate that structural variables might be more useful for understanding recommendation outcomes.

A distance matrix was thus derived for the practices involved. For convenience, linear

distances between practices were calculated and set up as a 49 x 49 square matrix of mileage values. The distances between practices ranged from as low as 5.706 miles up to 155.311 miles. Once it was established that a significant association existed between percentage of colonoscopies recommended and distance between practices, the original distance matrix was systematically dichotomized at different values and tested to identify the range of associations between different path lengths and percentages of colonoscopies that yielded the best explanation of variance in models. Values for the various shorter path lengths were calculated as less than or equal to a maximum of 76 miles and a minimum of 16 miles. I included additional values at 50, 60, and 70 miles for the upper end of distances. QAP regressions were run on each shortened path model and a range of values identified that appeared to best fit data. Models with paths ranging from less than or equal to 70 miles to less than or equal to 50 miles resulted in similar R^2 and adjusted R^2 values, but significance values for the independent variable identify the best fit for the data at a path length of 66 miles.

Closeness centrality, along with three other measures of centrality (degree, betweenness, and eigenvector) were calculated using UCINET's command for multiple measures of centrality for each of the shortened path models from less than or equal to 70 miles to less than or equal to 50 miles. This assured the normalized values of closeness were calculated such that the higher the value of the closeness variable, the more central the node. Closeness product matrices were generated and re-run as independent variables in QAP regressions for each of the shortened path models. Comparisons were made among the R^2 , adjusted R^2 , and significance values to again identify the break point in values that suggested which model best fit the data (See **Table 2**). **Table 3** reports the results of the final QAP Regression Model using the closeness centrality values for distances less than or equal to 66 miles).

Finally, a small table (**Table 4**) of values was devised to suggest the relationship between distances colloquially thought of "as the crow flies" and the time it takes to travel along different roadway types at a particular speed limit. This last table is merely an estimate of the effect travel distances. The relative times of travel associated with each road type can be related to common sense decisions to recommend or not recommend a patient for colonoscopy.

Table 2: Comparisons of Model Fit Using Different Maximum Path Lengths

Distance	R ²	Adjusted R ²	Significance
Linear distance between practices	0.217	0.213	0.045
Distance <= 76 miles	0.220	0.216	0.017
Distance <= 70 miles*	0.224	0.220	0.003
Distance <= 66 miles	0.226	0.222	0.002
Distance <= 60 miles	0.223	0.219	0.002
Distance <= 56 miles	0.223	0.219	0.002
Distance <= 50 miles*	0.221	0.216	0.006
Distance <= 46 miles	0.218	0.213	0.024
Distance <= 36 miles	0.215	0.211	0.067
Distance <= 26 miles	0.215	0.210	0.105
Distance <= 16 miles	0.214	0.209	0.224

**Break points in significance levels appear to occur between 76 and 70 miles at the upper bound and 50 and 46 miles at the lower bound.*

Table 3: QAP Regression Results Using Distance Between Practices as Independent Variable as Opposed to Assessment Results

Independent & Control Variables	Significance	Proportion as Large	Proportion as Small
Linear distance between practices	0.045*	0.956	0.045
Lake Cumberland ADD	0.092	0.092	0.909
Bluegrass ADD	0.006*	0.995	0.006
Buffalo Trace ADD	0.023*	0.023	0.977
Cumberland Valley ADD	0.387	0.387	0.613
Fivco ADD	0.344	0.344	0.656
Gateway ADD	0.383	0.383	0.617
KY River ADD	0.002*	0.002	0.998
I-64	0.298	0.298	0.703
I-75	0.468	0.468	0.533
R-127 & R-150	0.203	0.203	0.797
R-25 & R-119	0.019*	0.982	0.019
R-68	0.057	0.943	0.057
Middle routes	0.223	0.778	0.223
R ²	0.217		
Adjusted R ²	0.213		
Probability	0.000		

* Significant at $p = 0.05$

Results

Table 3 reports the results of the first model, which tested whether there was

Table 4: Comparisons of Model Fit Using Closeness Centrality at Different Maximum Path Lengths

Closeness Centrality at $\leq X$ miles	R^2	Adjusted R^2	Significance
Distance ≤ 70 miles	0.327	0.324	0.001
Distance ≤ 66 miles ^{† ††}	0.357	0.353	0.002
Distance ≤ 60 miles	0.321	0.318	0.005
Distance ≤ 56 miles [†]	0.357	0.353	0.001
Distance ≤ 50 miles	0.339	0.336	0.001
[†] Closeness centrality appears to have similar impacts at both Distance ≤ 66 miles and Distance ≤ 56 miles.			
^{††} At Distance ≤ 66 miles, not only were the control variables for location in Lake Cumberland, Buffalo Trace and KY River ADDS statistically significant, but the Bluegrass ADD control becomes statistically significant as well; Bluegrass ADD not significant at Distance ≤ 70 miles or below at Distance ≤ 60 .			

significant association between the linear distance matrix and the percentage of colorectal cancer screening recommendations. As in all the rest of the models, I used the seven ADD matrices and six roadway matrices as controls. The R^2 and adjusted R^2 values were a respectable 0.217 and 0.213 respectively. The probability of the model results was 0.00, indicating that the results were not by chance alone. The significance level of practice distances was also significant at $p = 0.05$, which was much better than previously tested models using attitude and consensus measures from practice providers. Three of the ADD controls and one of the roadway controls also demonstrated significant association to screening recommendations. I used these results to justify dropping the attitude and consensus measures.

At this point, I began to wonder if there was a way to differentiate the distance values toward some kind of limited range that could make it easier to question the mechanisms at work that made distance a useful predictor. I next tried varying the length of paths to see if there was some kind of upper or lower limit to the effect of distance. I ran several models at less than or equal to 56, 50, 46, 36, 26, and 16 miles. I chose values of 6 mainly because I noticed that the raw data included three decimal places. I had originally thought of using multiples of five as a starting place for making distinctions, and rounding up to a value of six was a somewhat arbitrary decision on my part.

I ran the multiple measures of centrality available in UCINET and found that smaller

values of distance stopped producing significant associations. Actually, at less than or equal to 26 miles, the network splits into two components and measures of centrality no longer appeared to be relevant. Degree centrality at less than or equal to 36, 46 and 56 miles had an equally good results to closeness centrality, but also provided a different pattern of significance among the ADD and roadway controls. I decided to increase the set of distance relations as far as necessary to find out if there were different types of centrality at work in different areas of the region.

Table 4 shows the results of my increase in maximum values up to less than or equal to 70 miles and base centrality measures on these longer networks. Break points in significance levels appeared between 76 and 70 miles at the upper bound and 50 and 46 miles at the lower bound in **Table 2**, indicating a loss of ability o distance alone to explain model results. In **Table 4**, the pattern of fit among models fluctuated such that closeness centrality appears to have similar impacts at both less than or equal to 66 miles and less than or equal to 56 miles. Both models had identical R^2 and adjusted R^2 values. The difference in significance varied with the number of times I ran the model as well as with the number of permutations, but basically stayed similar to that listed in the table. The major difference occurred in relation to control variables. At less than or equal to 66 miles, not only were the control variables for location in Lake Cumberland, Buffalo Trace and KY River ADDS statistically significant, but the Bluegrass ADD control becomes statistically significant as well; Bluegrass ADD not significant at less than or equal to 70 miles or below at less than or equal to 60. This result also appeared to resolve the issue as to whether there were two kinds of centrality at work in the region.

Table 5 displays the results of the final QAP regression model using normalized closeness centrality values measured at path distances of less than or equal to 66 miles. The probability of the result was 0.00, indicating the results are not merely by chance. The R^2 and adjusted R^2 values were 0.357 and 0.353 respectively. Most importantly, as mentioned above, four of the ADD control variables and three of the roadway control variables also yielded significant associations. The high quality of the model fit along with the increased number of significant control variables suggests this model is sound as a predictor of how network closeness centrality is related to recommendations for colonoscopy.

Table 5: Final QAP Regression Results Using Distance Between Practices as Independent Variable as Opposed to Assessment Results

Independent & Control Variables	Significance	Proportion as Large	Proportion as Small
Closeness Centrality (Distance <= 66 miles)	0.001**	0.001	1.045
Lake Cumberland ADD	0.020*	0.020	0.981
Bluegrass ADD	0.048*	0.953	0.048
Buffalo Trace ADD	0.022*	0.022	0.978
Cumberland Valley ADD	0.352	0.352	0.648
Fivco ADD	0.289	0.712	0.289
Gateway ADD	0.327	0.327	0.674
KY River ADD	0.036*	0.036	0.965
I-64	0.435	0.298	0.703
I-75	0.191	0.191	0.810
R-127 & R-150	0.043*	0.043	0.957
R-25 & R-119	0.001**	1.000	0.001
R-68	0.011*	0.989	0.011
Middle routes	0.103	0.898	0.103
R ²	0.357		
Adjusted R ²	0.353		
Probability	0.000		

* Significant at $p = 0.05$; ** Significant at $p = 0.001$

Discussion and Conclusions

As discussed above, I think what is being measured by the model in this study is possibly a proxy for local common sense understandings about how long it takes for someone or something to get from one site to another within the region. Since the distances used are linear, “as the crow flies” distances, it is their intersection with the place variables of ADD and roadway where they start to make sense. In this sense, the closeness centrality measure points to the reality of sending a “package” across a large space, when the primary package is a human being. If we understand the 66 mile maximum as a proxy for drive time, we can calculate driving times for different road types (See **Table 6**). A 66 mile trip over a four lane interstate like Interstate 64 or 75 is only about an hour travel. Across a two lane rural route, or even on a one lane country road, where are likely to range from 45 to 55 miles per hour, a 66 mile trip grows to 72 and 87.5 minutes, respectively.

Colonoscopies are a time consuming screening process. Individual give a day to

Table 6: Estimated Driving Time by Road Type, Speed Limit, and Time Needed to Drive 66 Miles

Road Type	# of Hours to Drive	Speed Limit (MPH)	Minutes to Drive 66 miles
Interstate and Four Lane Parkway	1.02	65	61.2
Two Lane Parkway and Full Width Roadway	1.2	55	72
Single Lane and Construction Zones	1.46	45	87.6

prepare for the procedure as they take medication to clear the bowel prior to the procedure. A second day can be lost to the procedure itself, because the person receiving the procedure must be sedated and is not likely to return to work after the procedure as and must have someone drive them home after being sedated. It is possible, then, that, since closeness centrality can be thought of as an index of the expected time of arrival of something flowing through a network (Borgatti, 1995; 2005), the 66 mile measure of centrality is measuring the effect that recognizing one has a trip of up to 90 minutes tacked on to an already time-consuming procedure. Providers may well include assessment of an individual's motivation to endure both the procedure and the effort and expense of follow through in their decision to make an recommendation.

Another interesting issue is the fact that time-of-arrival may also be related to complications that impact delivery of other elements of the package. Record delivery can be complicated by distance, as well as the expense of delivery at greater distances. We did not have data to assess the team work needed to carry out the recommendation once it is made. Further research might focus on the relationship of team involvement and the complications that arise in recommending colonoscopy. How the overall cost and difficulty of making recommendations taxes a practice's staff, particularly in small rural practices, is a matter for ethnographic research to investigate how different practices cope with the constraints imposed by their environments as well as how such coping patterns show up in the communication and assessment of outcomes used by the practices to assess their cancer control and prevention efforts.

In terms of the work of the cancer prevention coalitions in the region, this chapter has

explored a major constraint that motivates coalitions to undertake 501©(3) status and engage in fundraising as a way to address difficulties supporting patients who cannot afford the additional expenses that accompany a referral for screening or other cancer services. Such a constraint and its perceived solution are directly related both to the rising costs of healthcare and to the withdrawal of states from the social safety nets that once accompanied poverty reduction strategies. The coalitions are thus called upon to help various medical practices make value out of the screening referral process by trying to subsidize externalized costs which fall outside the calculations of federal safety net accountability. In the place of a functioning social safety net, we find ever greater systems of electronic tracking and surveillance, greater refinement to about how many cases of cancer exist and how many screenings are being conducted to detect them. We also see new systems to speed the electronic transfer of payment for services rendered. These technological systems increase the cost of doing cancer medicine business and are rationalized as a means for making services more efficient by increasing the speed with which information can be moved from place to place. Yet, when it comes down to it, in largely rural areas like eastern Kentucky, these technological systems increase capacity for services without enriching the local population in a manner that allows them to access the “benefits” of the emerging “information economy”.

To paraphrase Darin Barney’s (2000) critique of the new interactivity and democratization presumably being provided by modern electronic systems of communication, if the networks facilitated by these communication systems are as revolutionary as they are claimed to be, why are governmental, bureaucratic, corporate, and financial elites so enthusiastic and invested in them? What I find most disturbing about this is that the rhetoric of the mainstream advocates of cancer prevention deploys concepts of participation, choice, and personal responsibility even as control of the resources to act responsibility and participate are being channeled upward and away from the sites of greatest need. The rhetoric hides the shifting of responsibility for those who are financially unable to benefit from the new biotechnomedical marvels onto marginal communities who have not yet been unable to meet even basic needs. This rhetoric also allows those at the state and federal level make political claims that they are addressing the problems while shifting blame for the continuance of those problems back onto local

communities as failures to exercise the “choices” that are available.

The “prevailing social attitude” is that there is, at best, a political consensus that mandates the support for a transition to a service-based, information economy if the US is to be competitive in a globalized economy. This discourse also supports the corporatization and privatization of healthcare as a means to make the shift in the medical sector of the economy. Such changes are supposed to be transformative the miracles of interactivity and participation afforded by information technology allow us to move from simply being passive recipients of technology and information to active participants who express their individuality through our consumption choices. Andrejevic (2004) notes that this promise of interactivity and democratization emerged in the 1970s just as the US began to experience the economic crises that led to the Reagan revolution and the turn to neoliberal economic policy. Just as the 66 mile/90 minute mark serves as a proxy for the willingness of physicians and patient to commit to a referral for colorectal cancer screening services, it also symbolizes the gap between the promised efficiency of technocratic intervention and the commitment of resources to assure that services are realistically available to all. Regardless of the ability of technology to facilitate information transfer over greater distances and in shorter and shorter times, this increased speed and efficiency is likely to only benefit those that have resources to exploit those efficiencies, hence maintaining or increasing existing inequalities over time.

Chapter Six: Using Critical Discourse Analysis to Explore Media Discourse Around Cancer in Eastern Kentucky

“Sensitive Issues” in Local Health Care Social Circles in Harlan County, KY

My purpose in this chapter is to explore ways that community solidarity is represented in local media. I will also examine the impact of the representation of this solidarity has on how the two cancer prevention Cultures of Action are represented. To accomplish my purposes I will use newspaper stories from the Harlan Daily Enterprise (HDE), a daily paper from Harlan County, KY. The starting point for examining these stories is the questions, “Whose voices are heard in relation to public health issues is the question?” “How are different voices positioned in local newspaper stories so that the diversity of viewpoints are acknowledged or ignored?” and “Are different voices given room to negotiate an interpersonal space for their own positions within that diversity (White, 2001)?”

If local media genuinely facilitates a “storytelling network” that supports civic engagement, it will also facilitate a public sphere where community concerns are given voice, even voicing “sensitive issues” that threaten civility. Marginalized groups will find opportunities to create spaces to be heard. Sensitive issues related to poverty and race constitute one area related to health disparities, but in Appalachia there are also issues of environmental justice which are having ever greater impact on the health and well-being of communities in the region. Local media plays a role in the structuration and reproduction of the region through the manner in which it tells community stories and how it draws on the local action context to frame positions and characterize community alignment in relation to issues. This framing and characterization includes how media stories represent community identity and the sensitive themes that threaten its stability.

Political Scientist Mark Warren (2006) defined an issue as “sensitive” such that it is sensitive to the background of social relations to the point that it fails to establish the kind of equality necessary for discourse—the equality of speaking, being heard, and listening that makes consensus-building possible. Following Habermas, Warren focuses on the importance of discourse in transforming cognitive claims into understandings so that they have a motivational force. In the case of sensitive issues, the intentions to act discursively which motivate various parties draw on background inequalities in a community context,

causing discursive performance to diverge from its intended meaning. The divergence, in turn, undermines the very possibility of discourse. People discount “what” is said simply because of “who” says it. Historically, hegemonic communication strategies, like “divide and conquer”, on the part of elite actors, exploit the tendency for divergence to assure that potential challengers to hegemonic positions are too busy fighting one another to join forces against elites.

Sensitive issues, according to Warren (2006), have instability-inducing characteristics: 1) the topic of conversation is visibly or audibly a part of the person, such that the “what” of statements immediately references the “who” of the person, prior to any verbal engagement; 2) These markers indicate an involuntary status inequality such that participants in a conversation cannot avoid being implicated in an initial inequality that must be corrected in order for a conversation to take place; 3) The status inequality violates deliberative interchange; 4) Status markers thus cue a background context that predisposes participants toward the judgment that their attempts at speech will be misunderstood.

Sensitive issues are embedded in the ideological buffers that establish, maintain, and assure support for the social dominance of particular social groups, while at the same time distancing marginal groups. As such, sensitive issues are triggers for boundary activation. Mentioning a sensitive issue leads to an increase in the salience of related social boundaries, hence the salience of related social identities, at the expense of others that are available (Tilly, 2007). Ideological positions make assumptions that are textured into texts via various types of implicitness, especially ‘presuppositions’, which vary in how they orient to difference, attempting to present a singular, monological voice, rather than being constructed in ways that display intertextuality and heteroglossia (Bahktin, 1981; White, 2001; Fairclough, 2003).

In Critical Discourse Analysis (CDA) as developed by Fairclough (1992; 2003), assumptions are related to intertextuality. The major difference between assumptions and intertextuality is that the former are not generally attributed or attributable to specific referential texts. Assumptions are more vague and are an example of the more general concept of implicitness (2003, p. 45). “What is ‘said’ in a text is ‘said’ against a background of what is ‘unsaid’, but taken as given. ‘Who’ is doing the saying is

foregrounded by ‘who else’ is supporting the position taken, but left undisclosed. An example can be found in one of the environmental stories drawn from the Harlan Daily Enterprise:

Dan McKenzie, a representative with the Rural Community Assistance Program, told Closplint residents their community's sewage system, which was first constructed in the 1920s or 30s, wasn't built to withstand the weight, vibrations and heavy pressure of coal haulage that has taken place in the area for decades. We all know we've got cracks in the system, here, McKenzie said. And this causes wastewater to not only spill into the creek, but to seep into your yards where it rises to the top of the grass (HDE, 11/19/2003).

We see in McKenzie's discussion of the antiquated sewer system a legacy for the community that assumes the community's acceptance of mining's detrimental effects on quality of services. McKenzie also assumes the mining industry is not accountable for that depreciation, even though the mining practices have affected the sewer system for over seventy years. In other words, “who” is historically, at least in part, responsible for the sewer system problems and “who” continues to create problems is separated from “what” problems are currently at stake. This framing privileges mine operators while marginalizing those who suffer environmental consequences related to mining. Regulation of mining at any level, whether limits on the practices used to mine coal, limits on how the environmental commons of the region can be appropriated for mining use, or even regulates local recuperation of damages for mining destruction, are not mentioned, or if they are, they meet with highly emotional reactions that include people's fears of losing their jobs and livelihood. At some level, assumptions about the value of mining and mining jobs push dangerous features of the industry into the background and silence voices oppositional to the industry and its negative impacts.

Since stories about upgrading the sewer system focus heavily on problems paying for the repairs, questions about what obligations the mining industry has to the communities are not broached. Other questions about the long-term health consequences for the community related to the continued exposure to polluted water ways or to stressful, dirty living conditions are rarely mentioned. Recent damage to the public works system in Harlan has been only one crisis in a history of similar destructive episodes, all of which are written off company books by local mining concerns as externalities, the cost the

local community pays for the opportunity to be employed in the energy industry. The technocratic codes of engineering, financing, and accounting remain the domain of local and state government and mine loyalists whose job it often is to smooth over public outcry and avoid messy legal confrontation over sources of public works destruction.

To answer my initial questions, I explore the intertextual, external relations by which local newspapers texts about cancer prevention are segregated from local community stories about the consequences of mining. In this chapter, intertextuality refers to the relationships between different types of discourse, such as genres, styles, and representations (Fairclough (2003). This broad definition of intertextuality includes various external relations textual elements, such as quotations, e.g. *Jane said, 'I will be late tonight'*; reported speech, e.g. *Jane said she would be late tonight*; and the ways a text can be incorporated into another text without attribution, e.g. *Jane will be late tonight*. How reported voices are then 'framed' (or contextualized) *inside* the main authorial voice of the text shapes these intertextual relations and may also import implicit assumptions into a text without calling attention to their sources (Gamson, 1990; Johnson-Cartee, 2004). Framing not only involves the relation of a reported voice to the authorial voice, but also the relation of various reported voices to each other, shaping explicit dialogue and possibly insulating assumptions from being questioned.

Both intertextuality and assumptions are claims by authors about what has been said or written by other people (Fairclough, 1992; 2003) and such claims may be deliberately or accidentally false. Questions about "what" dangers and risks deserve public attention and the positionings and framings concerning "who" is responsible for the dangers in the first place as well as who is culpable for responding to the threat are at the heart of what makes the social action context of a community opened or closed. A threat is newsworthy to the extent that it can cause damage, disrupt, or rearrange the social order in its material, political, or normative guise (White, 1997; Fairclough, 1999; Seale, 2002). It follows that the typical lifestyle-oriented argument related to health generally and cancer specifically is one that posits at least one normative (moral) breach (e. g., over eating, lack of exercise, smoking, etc.) as the source of the illness, while the physically destructive aspects of cancer, particularly if the disease is perceived as coming on quickly and in an unexplained way, may be described as a kind of aberration. When the growing

incidence of cancer is elevated to perception as ‘epidemic’, then it is also framed as a kind of aberration as well.

Voices claiming environmental causes for increases in cancer argue, instead, that there are power relations connecting government regulation and industrial or corporate malfeasance to increases in the cancer rate. The “contradiction between production and consumption” referenced in the Crawford quotation from the first chapter is a contradiction exemplified by actual incidences of hegemonic governmental/corporate collusion. The “collectively fashioned, mutually recognized, and endlessly rehearsed predicaments of attempting to improve health in a world of apparently unhealthy enticements provide a template for our larger predicament” is typified by the lifestyle solution proposed by traditional health promotion.

In the next section, I want to briefly discuss the idea of “social world” that will allow for further clarification of the relationship between text and context, situation and environment. Social worlds are a particularly useful sensitizing concept for understanding how discourses are implicated in the constitution of social arenas of contention like the differences between mainstream movement activities by groups supporting early detection and cancer screening advocacy and those groups or movements that advocate cancer prevention and environmental activism are playing out.

Social Worlds and “What” and “Who” in Local Social Circles

Social worlds are “built up” through the overlaps and linkages among and/or between social practices, as various actors come to articulate together their selected foci of social activities (Strauss 1978; Clarke, 2005; Crossley, 2012). In eastern Kentucky, cancer prevention coalitions are part of the infrastructure that facilitates these overlaps and linkages among and/or between the social practices of mainstream cancer prevention. Social worlds related to movements and collective action are dependent on media and movement actors are forced to compete with other voices for media attention (Gamson & Wolfsfeld, 1993). This fundamental asymmetry gives greater power to the media, particularly in how they represent the social practices and viewpoints the movement hold, as well as the ties the groups have to others in the community, particularly ties related to the boundaries buffered by sensitive issues related to class, gender, race, age, or disability. Since social movements need the news media for mobilization, validation, and

scope enlargement, media discourse is indispensable for most movements because the people a movement wishes to reach are part of the mass media audience. Movement's validation and standing in the media is often a necessary condition before targets of influence will grant recognition to a movement. When demonstrations and promotional activities get little or no media coverage at all, they are likely to become nonevents.

Warren (2006) says that most public discourse does not benefit from the "sheltered contexts of facilitated deliberative forums". Such forums have the "benefit of self-selection for people of good will". Political discourse can often be navigated with success by persons secure in themselves, skilled at equalizing within conversations, and responsive to what is said, giving an advantage to the articulate, well-educated, and well-prepared. Yet public discussions under such conditions do not reflect the unpredictability of many actual public conversations:

But with or without skills, the conversations are more likely to suffer shipwreck the closer issues touch on the identity of persons—the more speaking reveals, as Hannah Arendt put it, the "who" of the speaker. What neither Habermas nor Arendt develops is the negative side of the close relationship between the "what" of statements and the "who" of speakers: there are some issue contexts, race among them, that so entangle what is said with who says it that deliberation ranges from the awkward to the impossible. In such cases, it is no wonder that people are more readily drawn to silence or battle than to the tougher option of deliberation (Warren, 2006, p. 169).

To add to the complexity, organizational actors often have the resources to employ spokespersons whose job it is to frame issues to the press and keep the image of the organization in a positive light. We see in the HDE health stories that the local hospital, Harlan Appalachian Regional Hospital (HARH), and the American Cancer Society (ACS) have such persons. When examining the reporters credited with authoring health stories over time, many HARH and ACS stories were written by an author credited at different points in times as being employed by HARH, as a volunteer for ACS in another case, and as a reporter for the newspaper in yet another story. This person even shows up as a spokesperson for a state environmental agency in one of the environmental stories. At the same time, smaller, less financially-resourced local communities, businesses, charitable and advocacy groups, and churches do not have such spokespersons. In this chapter I treat the difference between these two sources as a status difference that is a proxy for

how community solidarity is misrepresented in the course of the newspaper selecting among expert and lay sources for materials in stories.

In his approach to media discourse, Fairclough (1995) suggests that linguistic variations in the representational process implicate and are implicated by the circulation of different categories of discourse, what he calls different discourse types. Discourse types shape how language is used from specific point of view to articulate social practices as particular representations. This vision of media language and texts as discursively constrained, situated, and motivated suggests the importance of social and discursive practices to account for the organization of meanings through interactions between different discourses in media texts. Studying how media texts utilize, reorganize, and transform different discourses provides insights into the processes of ideological and ‘reality’ construction in the media. In the HDE stories, individuals are often portrayed as representatives of a particular organization – a neighborhood or town, community organization, government agency, advocacy group, corporation, etc. Though individuals are the foregrounded agent, they are typically identified by their status in some organization. Exploring how the background assumptions about organizational affiliation grant expert authority to some sources, I argue that this status affects how source material is used to represent viewpoints in community issues.

The Dialogic View in CDA

Bakhtin’s (1981) notion of *heteroglossia* – dialogized interrelations of languages and discourses that involves multiple voices speaking through text- is a starting point for Fairclough (1992; 1995; 2003). Central to Bakhtin’s vision of language and text are the notions of stratification and intentionality. Stratification is used by Bakhtin in much the same way that a sociologist uses the term, to understand how orders of social reality are created by ideological bias. It is a process in which language departs from a unitary and fixed state in order to redefine and reorganize a new stratum of its own. As a process, stratification of language is a result of the interactions between different features of language in different contexts, with Bakhtin’s main focus being on the ‘intentional dimensions’ of language’s stratification. These intentional dimensions denote and express the specific points of view, purposes, approaches, and ways of thinking, which in turn, influence how languages come to be stratified. In many cases, though, official or

ruling discourses become fossilized and prevent the surfacing of voices from below. In this case, the heteroglossic text has been reduced to a monologue.

Stratification and recontextualization reorder the original languages, including its power relations, and belief systems, and redefine them in new forms of discourses. For Bakhtin, the ways that languages are reorganized or stratified involve specific ideological and sociopolitical positions that have implications for the identities of their advocates. Heteroglossia, from this perspective, is the competition of different voices, identities and positions to maintain, adopt, or abandon power and control. Languages and discourses in a text or set of texts are engaged in ongoing interactions that create new textual forms, new networks of relations. A critical examination of the production of media texts enables us to view media texts, not as singular, unified, and guaranteed productions, but as historically and socioculturally specific contexts with certain intentions. Media discourse should be treated, from the Bakhtinian tradition, not only in terms of its content, but also only in terms of its *intention* that reorganizes and regulates other discursive practices in a new order. Media representations, understood in this way, are reconceptualizations of observable linguistic markers according to specific intentions of those involved in the process of media production.

The heteroglossic perspective emphasizes the role of language in positioning speakers and their texts within the heterogeneity of social positions and world views which operate in any culture. All texts reflect a particular social reality or ideological position and therefore enter into relationships of greater or lesser alignment with a set of more or less convergent/divergent social positions put at risk by the current social context. Thus every meaning within a text occurs in a social context where a number of alternative or contrary meanings could have been made, and derives its social meaning and significance from the relationships of divergence or convergence into which it enters with those alternative meanings (White, 2001).

White (2001) is concerned with how texts deploy discursive resources for “positioning the speaker’s/author’s voice with respect to the various propositions and claims conveyed by a text; meanings by which speakers either acknowledge or ignore the diversity of view-points put at risk by their utterances and negotiate an interpersonal space for their own positions within that diversity”. Informed by Bakhtin’s dialogic vision of text, Fairclough (1992) maps out a version of CDA that attends to heterogeneous elements in

text construction. He draws not only on Bakhtin, but also the work of Kristeva (1980) to understand the “intertextual” nature of discourse.

Kristeva coined the term “intertextuality” as an attempt to synthesize Saussure’s semiotics, which emphasized how signs derive their meaning within the structure of a text, and Bakhtin’s dialogism, which examined the multiple meanings, or “heteroglossia”, in texts (especially novels) and in each word (Irwin, 2004). Kristeva wanted to replace the notion of intersubjectivity in text analysis because she believed that meaning in texts are not transferred directly from writer to reader but instead is mediated through, or filtered by, “codes” imparted to the writer and reader by other texts. As such, codes can be understood as part of the way the behavior and identities of social actors are transferred by the writer and given moral legitimacy as persons and their activities are recontextualized within a highly heterogeneous social field. Saussure’s stress on the importance of the relationship of signs to each other eventually came to be understood as one of the weaknesses of structuralist semiotics in what was increasingly being called a postmodern society (Chandler, 2002). The tendency of structuralist analyses to treat individual texts as discrete, closed-off entities and to focus exclusively on internal structures was noticed and critiqued by Kristeva and other poststructuralists. Attempts to study an entire “corpus” of texts also did not resolve the problem because the overall generic structures of the texts tended to be treated as strictly bounded. The structuralist’s first analytical task became to delimit the boundaries of the system and determine what is to be included and what excluded, which is logistically understandable but ontologically problematic. Because codes transcend structures in everyday situations, the semiotic notion of intertextuality was understood by Kristeva as a means of rectifying boundary definitions.

By referring to texts in terms of two axes, Kristeva’s ‘semanalysis’ attempted to analyze texts across a social field, or, following CDA, an “order of discourse” (Fairclough, 2003). In the Harlan stories, the *horizontal axis* of texts connects the author and reader of a text first by directly quoting some actors while only indirectly referencing others and leaving some voices out all together. The *vertical axis*, which for Kristeva connects the text to other texts, involves the ways that the thematic structures of the story sets of cancer prevention frame the direct references to actors and their organizations

(Kristeva 1980). Shared codes unite the two axes, with every text and every reading depending on prior codes to make sense. As an example, ideological codes like what Connolly (1981) called the “ideology of sacrifice”, shapes regional masculine roles primarily as family breadwinner, legitimating suffering and loss, and maintaining hope for a better life in the future for the region’s children. A very similar ideological stance has been described in relation to conflicts in Appalachia over Mountaintop Removal Mining (Bell, 2009; Bell & Braun, 2010; Bell & York, 2010; Scott, 2010).

The texts in the newspaper, then, are from the outset under the jurisdiction of other discourses, particularly discourses of economic development and technological advance, of which the Early Detection and Cancer Screening culture of action is one. The discourses impose a universe of associations and meanings on news stories drawn from their respective fields of contention (Culler, 1981), but reflect as well the bias of jurisdictional control. The task becomes recognizing how the texts orient to social differences, tracing intertextual relationships among networks of actors, organizations, and themes via direct or indirect reporting of speech (such as through quotations or summaries of interviewees and witnesses in news reports), and then using the thematic traces among texts, based on repeatedly used noun phrases and other influential words that reoccur across texts, to understand how the voices of different actors and the organizations they represent are positioned by authorial framing. By tracing orientation to textual difference and similarity based on the presence of networks of actors, organizations, and themes, it is possible to gain insights into how texts are stratified within the totality of historically- and synchronically-related texts of which any given text is a transformation. Hence, we are studying their role in the “structuration” of society (Coward & Ellis, 1977; Giddens, 1984; Fairclough, 2003).

Seeing the text as constituting social relations and practices, Fairclough explains intertextuality as “the property texts have of being full of snatches of other texts, which may be explicitly demarcated or merged in, and which the text may assimilate, contradict, ironically echo, and so forth” (1992: 84). Fairclough also makes distinctions between “manifest intertextuality” and “constitutive intertextuality.” While the former refers to how quoted utterances are selected, changed, and contextualized, the latter is concerned with how texts are made up of heterogeneous elements: generic conventions, discourse

types, register, and style (1992: 85). The distinction between intertextuality and assumptions is a variation of constitutive intertextuality. Analysis of both features allows the researcher to account for the ways in which intertextual elements are part of the dialectical constitution of social practice. The adaptation of local practices to institutional discourses described in a community newspaper media text can be conceptualized in concrete forms of text by using the concepts of *genre*, *discourse*, and *style* – three different yet interrelated ways in which discourse figures in social practice (Fairclough, 2003). Genres are conceptualized as ‘the specifically discursual aspects of ways of acting and interacting in the course of social events’ which have relative stability and fixity (2003. p. 65). The medical intake interview, for example, is a genre recurrent on occasions when people first establish a relationship with a particular physician or hospital. An analysis of a text in terms of genre, thus, can reveal how those recurrent text-types within it mark and contribute to particular social occasions. Discourses, according to Fairclough, are “ways of representing aspects of the world,” and “different discourses are different perspectives on the world . . . associated with the different relations people have to the world . . .” (2003, p. 124). Analyzing discourses can provide insights into the relationships between various social positions and identities as they are represented in a given text or set of texts. Finally, Fairclough defines styles as “the discursual aspect of ways of being, identities” linked to the process of identification – “how people identify themselves and are identified by others” (an example being a politician’s way of using linguistic resources for self-identifying) (2003, p. 159). This view of style as identity construction shares a sociolinguistic approach to style that considers style as an individual writer/speaker’s use of language as a resource to evoke particular personae. The writer/speaker is not just a responder to context, but a performer of context, defining situations, identities, relationships, and goals. Studying style from the perspective of persona management and identification, thus, is critical for an examination of the world views, values, ideologies, and positions to which people are committed.

Fairclough (2003) also suggests that each of the three aspects of discourse and intertextuality shapes and is shaped by various aspects of text organization and a range of linguistic features of text. While a particular linguistic relation or category such as modality may be relevant to all of the three types of meaning (actional, representational,

and identificational), there are specific features or aspects of text that are primarily associated with either genres, or discourses, or styles. I seek to enhance the materiality and multidimensionality of the textual analysis by combining CDA methods with social network analysis (SNA) to clarify the social structures that emerge from the texts in question. I do this starting from the intertextual, explicit aspect of texts as a means to open up their assumptive background. Utilizing the direct and indirect source references in the stories from HDE, I create network representations based on the affiliations among actors, organizations, and the qualitative category of meaning discussed in the text. Using this starting point, I develop a network analysis to visually explore how solidarity is represented in the population of stories from the local daily newspaper. Overall, solidarity is textured by the choices story authors make in selecting and positioning voices in the texts. I make the case that the emergent social structure is an ideological representation that is a compromise between the desire to provide a unified news discourse about local issues and the power media has to select among stratified community voices.

Methods and Data

Using the online search capabilities of Access World News (NewsBank), I sampled 137 newspaper articles from the Harlan Daily Enterprise newspaper. The paper is available in electronic form beginning in 2003 and has editions to the present, of which I sampled from the March, 2003 when I found the first relevant cancer prevention story until February 2010, when I stopped drawing samples. My original searches utilized the keywords “cancer” and “cancer prevention”. I eventually dropped national stories about cancer research findings because I wanted to focus on how the local social worlds related to cancer cultures of action were depicted. Additionally, I recognized that Harlan County Health Department (HCHD), HARH, and ACS constituted the primary organizations represented directly in cancer prevention stories, so I searched the database for stories about each of each of the three organizations.

Other search terms were deployed as well and I gathered coal-related environmental stories by first searching the data base for the keyword “environment”, and, successively after that, “water quality”, “sewer”, and “roads”, all issues I knew from discussions with regional residents are related to the destruction mountain-top removal (MTR) creates. I also did organizational searches for “Kentuckians for the Commonwealth” and “fiscal

court”, dropping fiscal court stories not related to the issues of interest. I tried using combination searches using successful search terms from both the cancer prevention and environmental samples, but found this strategy garnered no new stories that had not already been uncovered.

The result was a story set that included 91 health-related stories and 46 environmental stories. The health-related stories were sorted into four categories, three of which were stories associated with American Cancer Society (ACS), Harlan Appalachian Regional Hospital (HARH), and Harlan County Health Department (HCHD), and a fourth category I called “Profiles”. These are stories which may or may not have organizational affiliations with the three main organizations mentioned above, but tended instead to focus on “profiling” some exceptional individual who has responded heroically to cancer. The main focus of this chapter is analyzing the first three categories of stories, and the Profile stories will be addressed in the next chapter. The environmental stories were sorted by four categories as well, “water quality”, “sewer”, and “roads”, along with an organizational category for Kentuckians for the Commonwealth (KFTC). Though I had expected KFTC to be a dominant story category, it was actually sewer-related stories that turned out to be the largest story category in the environmental subset, and as we will see, provides the most important overlap between the health-related and environmental story types.

Each story subset (cancer prevention/healthcare, environmental, and profiles) were analyzed using Centering Resonance Analysis (CRA) (Corman, Kuhn, McPhee, & Dooley, 2002). Textual networks constructed via CRA were visualized and mathematically analyzed using graph theory. A word’s significance, or influence, was calculated according to the position of the word in the CRA co-occurrence network as measured through the CRA process. Within the CRA paradigm, influential words in a text are central nouns or noun phrases that create coherence in the text, and, analogically, serve a similar function in text networks to boundary spanners in social network analysis. CRA methods are not based on word frequency, like traditional text analysis methods, but instead use grammatical rules to understand how words are being used in context. This avoids problems with methods based on word frequency that create insight based on models of stories as a “pile of words”. CRA creates insight through applying network

analysis to uncover the “flow” of meaning that gives a text its local coherence structure. Theme analysis based on a factor analysis approach was then executed to draw out important themes across the story sets.

Networks were extracted from the newspaper stories initially as qualitative actor-by-story matrices, organization-by-story matrices, and actor-by-organization affiliations. For the most part, qualitative categories were initially focused on direct quotes from actors represented in the stories. In doing so, the networks are grounded in direct quotations and establish dialogical, intertextual linkage among actors, organizations, and stories (Fairclough, 2003).

Affiliation networks were analyzed in terms of their 2-mode coherence, centrality and core/periphery structures (Borgatti & Haglin, 2011). They were also broken down into single mode actor-by-actor, organization-by-organization, and story-by-story networks. These networks were analyzed in relation to several forms of network centrality. In particular, networks were explored in terms of their betweenness centrality to understand which actors were positioned as most important to the flow of communication represented in the social world of the story sets.

The CRA software allowed me to use the program’s “classifier” interface to cluster CRA Networks based on resonance, a measure of similarity at the story level. The resulting resonance (.rsn) file includes a similarity matrix, whereby each cell of the matrix provides a correlation value between pairs of corresponding CRA files (Resonance values can differ as a function of the size of the two CRA files involved – larger files contain more words and can have more possible resonances with other files despite the informational or propositional contact). Even though the measure is normalized between 0.0 and 1.0, larger files tend to have more opportunity for resonance to occur and thus larger resonance values. Resonance is a form of vector correlation, with the size of the resonance value being similar to a correlation value. A resonance value between two CRA networks of 0.2-0.4 are considered small, 0.4-0.6 are moderate, values of 0.6-0.8 are strong, and above 0.8 is very strong. At resonance values greater than 0.2, the resonance network generated for the complete set of HDE stories broke up into seventeen different components of two or more stories. In order to preserve a more connected structure in the HDE story network, the tie values greater than 0.1 were used as a starting point to build a

network. The 0.1 resonance value was chosen somewhat arbitrarily because it was a round number, but also, because it generated a network that maintained the large complete components before the story clusters fragmented toward the seventeen highly differentiated components at a resonance value of 0.2.

Story Similarities

Figure 1: HDE Stories Linked Based on Similarities (Tie values greater than 0.1) is the resulting network at tie values of greater than 0.1, once isolates have been removed. The network exhibits basic clustering that will later affect thematic analysis. The important thing to notice here is the way that the two cultures of action become apparent as the stories separate into components, with the large component that stretches from the top left past the top center including environmental stories while the other groupings involve health stories. **Figure 2: HDE Stories Linked Based on Similarities (Tie values greater than 0.1; two main components)** is the same network further reduced by removing the smaller clusters and the penultimate nodes from the main components. This network is labeled to illustrate where some of the important story groupings are located.

In Figure 2: HDE Stories Linked Based on Similarities: Two Main Network Components, the lower component includes clusters of stories related to Relay for Life (the American Cancer Society), Breast Cancer Awareness Month (particularly activities by the Harlan County Health Department) and the stories about Harlan Appalachian Regional Hospital. The upper component includes stories related to area mining-related deaths in the year 2006 and stories about expansion, construction, and maintenance of local sewer, water quality, and solid waste disposal projects. Where story dates in the lower component tend to span the seven year period from which the stories were drawn and reflect the cyclic nature of local health-related promotions, clusters in the upper component have dates that can be more readily ordered sequentially into clusters that span at least two consecutive time frames – 2006 for the mining death stories and 2003 and 2006 in the sewer system stories. Following Fairclough (1992), this suggests that intertextual relations in the lower component do not rely heavily on sequential context to be coherent; their local history is not needed in order to be understood. They will tend to have a situational context of interpretation focused mainly on cues within the texts themselves. Upper component stories are more likely to need the sequential context of

Table 1: Selected Health Story and Environmental Story Cliques (Based on Complete Org by Cat network) lists the story dates and the headlines from the set of stories in the “Breast Cancer Awareness” and “Mine Deaths and Environmental Activism” clusters. The importance of listing the story headlines is that one can begin to

Table 1: Selected Health Story and Environmental Story Cliques

40 cliques found overall in the entire data set.

Health Stories

ACS Cliques (left out clique #1 due to size)

2	ACS	CVDHD	Dons Super Saver	Harlan ARH	Harlan Circuit Court Kentucky State Government	Kentucky State Government	Walmart
6	ACS	CVDHD	Harlan ARH	HCHD	Harlan Circuit Court Kentucky State Government	Kentucky State Government	
7	ACS	Harlan ARH	Harlan County 4-H	HCHD	Harlan Circuit Court Kentucky State Government	Kentucky State Government	
9	ACS	Harlan ARH	HCHD	James A. Cawood High School Kentucky State Government	Harlan Circuit Court Kentucky State Government	Kentucky State Government	
10	ACS	Harlan ARH	James A. Cawood High School Kentucky State Government	Harlan Circuit Court Kentucky State Government	Harlan Circuit Court Kentucky State Government	Kentucky State Government	
15	ACS	Cumberland High School	Cawood High School	Government	Harlan Circuit Court Kentucky State Government	Kentucky State Government	

Environmental Stories

KFTC Cliques

13	Benham City Council	Harlan County Fiscal Court	International Coal Group	Kemper community Kentucky State Government	KFTC	KCA
17	KFTC	KCA	KSBCCTC	Lone Mountain Coal Company	MACED	
25	Black Mountain Resources Christians The For	Harlan community James River Coal Company	KFTC	Pike County resident	Nashville community	
28	Mountains		KFTC		Vicco resident	

Additional cliques implicated with KFTC

16	Esq., Lexington, Kentucky	KCA	KDEP	Kentucky State Government	Marshall Miller and Associates	
11	Appalshop	Blackey community representative	CTC	Harlan County resident	Kentucky State Government	Letcher County Magistrates Court

natural world, which are studied by science. Social agents are not totally free to do whatever they want, but, on the other hand, their actions are not totally pre-determined either. Social agents have their own causal powers and their causal powers are not just part of (or produced or determined by) the causal powers of social structures and social practices, meaning they have some freedom to act. CDA assumes this is true about how social agents act in general, and more specifically, it is said to be true in terms of how social agents act in making ('texturing') texts - even though there are limits on how they can make texts, social agents still have a lot of freedom to shape events in the social world. Attending to the ways story clusters suggest that story frames will organize the causal powers of agents, structures, and practices gives us an important starting clue to understanding how the intertextual organization of text populations is representing agency and structure, and hence, possibly making ideological assumptions about the meaning of social events represented in the story population.

Orders of Discourse and Core Action Types Related to Cancer Screening and Coal Mining

Foucault (1971) began his famous paper "Orders of Discourse" in the following manner: "I am supposing that in every society the production of discourse is at once controlled, selected, organised and redistributed according to a certain number of procedures, whose role is to avert its powers and its dangers, to cope with chance events, to evade its ponderous, awesome materiality." (p. 8). He argued that the order of discourse is controlled by certain functions, actions, or rules. In particular:

- certain topics are prohibited
- reason is valued and madness is ignored
- the will to truth: "[T]he highest truth no longer resided in what discourse was or did, but in what it said: a day came when truth was displaced from the ritualized, efficacious, and just act of enunciation, towards the utterance itself, its meaning, its form, its object, its relation to its reference" (p. 1462).
- what we choose to comment on
- the author function (attributed to author so must be true, is it part of the author's "work", does it disagree with what else the author says)
- disciplines (excludes that which does not belong in the field)
- distribution limited
- who speaks is limited

Fairclough (1992) argues that discursive practices, the ways that texts are articulated

to social context, are constitutive in both a conventional sense that they are part of the reproduction of society, and in the creative sense that they contribute to transforming society. Strauss and Corbin (1993) discussed the agentic aspects of similar themes in interactional terms in relation to work discourses and “working things out”. Working things out is the interactional process through which arrangements are established, kept going, and revised. The process may or may not become contentious even though it consists of a series of interactional strategies and counter strategies taken by participants as they go through the process of making of arrangements before and after the actually work begins. The interactional strategies may include negotiating, making compromises, discussing, educating, convincing, lobbying, domineering, threatening, and coercing (Strauss 1978). One could argue that the interactional strategies of working things out exhibits forms of capillary power exercised by participants, though, I think it is important to appreciate that, even as actors involved in local negotiations work things out, they each come to the table situated in different places in the social landscape, control different resources and skill sets, and may or may not be empowered by their institutional positioning to exercise any degree of discretion as they engage in negotiations.

Crawford's (2000) health promotion dilemma is, in a sense, a tension between efforts to standardize and codify meanings ways of life that assure successful health outcomes and efforts to explore and indulge consumptive behaviors that open persons to diverse ways of living that give meaning to existence. Dixon-Woods' (2001) two discourses in the literature on how doctors communicate medical information to patients is an example of this tension. Her research indicated that the first discourse, the larger of the two literatures, reflects traditional biomedical concerns. Typically, this literature invokes a mechanistic model of communication in which patients are characterized as passive and open to manipulation in the interests of a biomedical agenda. The second discourse draws on a political agenda of patient empowerment, and focuses on the use of leaflets as a means of democratization, and its orientation towards patients. Dixon-Woods (2001) suggested that the two discourses, though distinct, are not entirely discrete, and may begin to draw closer as they begin to draw on a wider set of resources, including sociological research and theory, to develop a rigorous theoretically grounded approach to patient information leaflets. Both literatures appear to be based in the historic framing

of the doctor-patient dyad and I would argue that both are subject to the same error of treating the medical encounter as a dyadic one rather than some variation on configurations of triadic and larger groupings that tie parties together or distance them in the encounter.

Social Worlds Theory, as developed by Strauss (1978; Unruh, 1979; 1980), and incorporated into the Situational Analysis methodology by Clarke (2005), has other parallels with the Foucaultian ideas about orders of discourse in the ways it conceptualizes action, interaction, and discourse as central to the organization of social worlds. Clarke (2005:52) has stated that while action is at the heart of Strauss's project, power is at the heart of Foucault's work, and the two theoretical positions meet in the ways they relate social practices to processes of action and change. Clarke stresses that concepts of practice, whether discourse/discipline and regimes of practice in Foucault, or social worlds/arenas and negotiated orders in Strauss, are not equivalent but related by their emphasis on social practice and discourse. In effect, while both Foucault and Strauss emphasized discourse as being constituted through interaction (Clarke, 2005), Strauss saw social worlds as "universes of discourse" which are subject to processes of negotiation, while Foucault placed discourse far more explicitly in frames of power effected by disciplining practices that produce subjects/subjectivities through surveillance, examination, and various technologies of the self, often through the influence or the imposition of powerful social groups (Clarke, 2005: 54). Both positions square easily with the Bahktinian ideas about heteroglossia, which roots language social interaction, rather than being an abstract and politically neutral system of signs (Vasconcelos, 2007). For Bahktin, language was framed within social struggles (negotiations) which he described as tensions, expressed in the form of a conflict, between centripetal forces, focused upon the production of standardized and codified meanings expressed in dogmas and accepted views of universal truth, and centrifugal forces that promote diversity and variation informed in different and alternative discursive genres. The tension between centrifugalism and centripetalism, between standardization and diversity acknowledges the power dynamics pointed to by Foucault while also leaves room for the kinds of negotiations Strauss understood as necessary to the "working through" needed to organize work as a division of labor in a social world ().

In Fairclough's Foucaultian version of CDA (1989; 1992; 1999; 2001a; 2001b; 2003) languages are thought of as social structures which define the potential possibilities for texts. Orders of discourse mediate between the abstract level of languages and the concrete level of texts, actuating some meaning potentials and constraining others. An order of discourse, defined as the social organization and control of linguistic variation, is made up of the network of social practices, particularly inter-discursive practices that constitute the order of discourse as a network. Orders of discourse are made up of the discourse conventions that express different kinds of meaning. These conventions, Discourses, Genres and Styles, are not purely linguistic categories: they refer to phenomena which exist at the boundary between what is language and what is non-language and, as mentioned before include three types of meaning (actional, representational, and identificational). As we move from the analysis of abstract social structures down to the analysis of concrete social events and their texts it becomes more and more difficult to separate language from other elements of the social world. As Louis Althusser would suggest, language becomes increasingly 'overdetermined' by other social elements.

We can see social life as interconnected networks of social practices of diverse sorts (economic, political, cultural, family etc). The reason for centering the concept of 'social practice' is that it allows an oscillation between the perspective of social structure and the perspective of social action and agency – both necessary perspectives in social research and analysis. By 'social practice' I mean a relatively stabilized form of social activity (examples would be classroom teaching, television news, family meals, and medical consultations). Every practice is an articulation of diverse social elements within a relatively stable configuration, always including discourse (Fairclough, 2001a, p. 1).

Social practices, as articulations (connections) of different types of elements of the social world which are associated with particular areas of social life, connect concrete expressions of discourse and their meaning to other social elements dialectically. That is, each element partly internalizes, or contains, the other. So, for example, social relations are partly a matter of discourse (how we talk to each other) and, partly a matter of social relations (how we behave to each other). Social events are causally shaped, but not absolutely determined, by networks of social practices. In Kentucky, the Kentucky Cancer Action Plan and Kentucky Women's Cancer Screening program involve an array

of purpose-driven genres which give many cancer prevention practices a determinate structure, realizing biomedical practice associated with cancer prevention through state level instrumental social systems. If the Lifeworld is predominantly organized by communicative rationality and communicative interaction, Lifeworld experiences must involve genres that do not have such a determinate structure (Fairclough, 2003). Though much of the health promotion activity of the Early Detection and Cancer Screening Activism COA lays claims to a “grassroots” or Lifeworld basis, I would argue that grounding in KWCSF and its guidelines actually give the COA a Systems-centered ordering principle with the power to “colonize” Lifeworlds rather than allow them to “speak truth to power”. It follows that a basic problem for a discourse analysis of the Early Detection and Cancer Screening Activism COA is not confuse the tendency towards purpose-driven genres in modern social institutions with local genres in a general sense. One must attempt to sort genuine expressions of community sentiment from promotional culture (Wernick, 1990; Fairclough, 2003) that hijacks survivor narrative and other forms of communal speech in service of “tell-and-sell” texts (Fairclough, 1992) that disguise sales pitches within medical information giving. Over-privileging purpose in defining genre as a research focus invites the researcher to fall prey to ideological tendencies in political culture to legitimize what Habermas calls the “pathological” over-extension of systems and instrumental rationality into the lifeworld – the “colonization” of the lifeworld.

Table 2: Dialectics of Discourse: Cancer Screening as Social Practice (see the Appendix) is an effort, using the Kentucky Women’s Cancer Screening Program as an example, to illustrate what Fairclough (2003) is suggesting. For Fairclough (2003), there are five social elements, Action and Interaction, Social Relations, Persons, The Material World, and Discourses, that are articulated dialectically as part of a social practice via orders of discourse. Fairclough (2001b) argues that a “discourse can only work in so far as it achieves a high level of adequacy with respect to the realities it selectively represents, simplifies, condenses – in so far as it is capable...of being used to represent/imagine realities at different levels of abstraction, in different areas of social life (economy, government, education, health, regional and social disparities etc), on different scales (international, macro-regional, national, local)” (2001b, p. 10). As an

Table 2: Dialectics of Discourse: Cancer Screening as Social Practice

Elements articulated in social practices	Action and Interaction	Social Relations	Persons	The Material World	Discourses
Cancer screening as social practice	Comprehensive health history	Provider-recipient	Licensed physician, nurse practitioner, or physician assistant	Cancer screening and surveillance technologies	Discourse of the Early Detection and Cancer Screening Activism COA
	Physical examination	Recipient - family	RN with DPH approved Breast and Cervical Cancer training course	Medical samples for lab work	Administrative discourses which shape provider preferences, and recipient eligibility and confidentiality
	Referral	Provider – recipient family	Allied health support professionals	Educational materials and promotional incentives	Discourses defining payment sources
	Documentation of return clinic appointments	Volunteer – potential adherent	Reception	Out of pocket fees and insurance payments	Interview and exam formats; notes and transformations into billing documentation
	Follow-up of abnormal results	Provider – payer source	Screening recipient(s)	Medicaid or Medicare payments	Referral and follow-up scripts

order of discourse within the modern “knowledge-based economy”, screening discourses have a partially discursive and partially material character. KWCSF serves as a “plausible imaginary” intended to “attract investments of time and money to prepare for the imaginary future it projects, material factors which are crucial to making imaginaries into realities” (2001b, p.10). It is a discourse, but not just a discourse –it is materially grounded and materially promoted, being one aspect of a broader, technology-driven, biomedical framework that is not just a political economic factor in the healthcare economy of Kentucky, but part of what theorist Bob Jessop (2009) has called a “cultural political economy”. As a part of the cultural political economy in the US, KWCSF incorporates a theory of discourse in terms of its policy rhetorics that limit its powers to within the state of Kentucky, but also draws on national and international discourses in

terms of the discourses of health promotion, patient compliance, etc. It transforms and recontextualizes the recommendations and planning in the Kentucky Cancer Action Plan (Kentucky Cancer Consortium, 2010) and incorporates the rhetoric of “best practices” and the economics of block grant Medicaid funding. This broad order of discourse is articulated by the dialectical of discourse in terms of how discursive construals of the world can come to construct and reconstruct the social worlds of communities as they incorporate the Early Detection and Cancer Screening Activism COA and its social practices into the community’s everyday practices, specifically in terms of how practices of public-private partnership are deployed through the position of county health departments in the Early Detection and Cancer Screening Activism COA. The order of discourse involved never loses sight of the material reality of the world, or the conditions which the material reality of the world sets on the discursive (re)construction of the world, not simply because it is focused on a promoting a valued biomedical procedure, but also because modern biomedicine has become “big business” within an “information-based” economic sector (Klawiter, 2008).

The five actions/interactions listed in column two of the table are mandated in KWCSP and positions different persons into a set of social roles by prescribing social relations to be implemented as part of the practices of screening. The practices require certain material technologies as well as biological samples from recipients of screening. Discourses are intimately involved with selecting which providers are eligible to provide services, defining who is in need of those services, how the services will be paid for, and who is culpable if something goes wrong. The discourse define who are considered “risky subjects”, to use Klawiter’s (2008) terms, how they are to be detected, and how they are to be disciplined once they are identified and brought under the biomedical gaze. The social practices surrounding screening are networked together to form an order of discourse that is constrained by the rules and regulations of KWCSP. They form an orientational order of practices around which all the other discourses within the Early Detection and Cancer Screening Activism COA in Kentucky are centered.

The meaning of screening practices and the news texts that discuss them are “polysemous” (Hebdige, 1979). Texts about screening generate a range of meanings that create a ground against which links and analogies to community life can be formed. This

helps to 'position subjects' in relation to the medical system and make that relationship appear natural. Cancer screening-related stories become a kind of bricolage (Levi-Straus, 1958), a hybrid that cobbles together references to the various social elements related to screening practice into “tell-and-sell” promotional culture (Fairclough, 2001b). The KWCSF is a primary source for professional attitudes about screening practices Kentucky service providers, particularly those accessing Medicaid. This is particularly as those attitudes are “projected” (Martin & Rose, 2003) into the news. “Projection” here has to do with the relationship between who is quoted or referred to as a source of information and what the source actually said. Projection can be accomplished directly, through a quotation, or indirectly through paraphrasing and summarization. This kind of direct or indirect referencing of voices and the projection of those voices into a text has the effect of increasing the dialogicality of a text (Fairclough, 2003). Assumption, which occurs without any reference to the source voices, decreases dialogicality and masks the voices interacting in a text. That cancer prevention discourses so consistently fails to explore the range of meanings available to them, particularly in relation to environmental issues affecting the incidence of cancer in marginalized communities, suggests significant constraints on source materials within the Early Detection and Cancer Screening Activism COA.

Technically, one could develop a propositional analysis such that every verb, adjective, adverb, conjunction, and preposition could be considered an idea (proposition) (Brown, Snodgrass, Covington, Herman, & Kemper, 2008). Analysis based on the micro-textual features of the news story would be excessive for my purposes. The CRA methodology reduces the complexity of the analysis by extracting textual features based on the similarity of semantic centers (noun phrases) across a population of texts. One can further reduce the complexity of analysis by moving to the level of generic structure of stories. The nucleus-satellite generic structure of the news stories has been studied in recent years as a common feature of newspaper story organization (Iedema, Feez & White, 1994; White, 1997a; White, 1997b; White, 1998; Fairclough, 2003). The nucleus of a news story is made up of the story headline and lead paragraph, which introduce the story focus, whether it is a news event, or issue, either hard or soft news. Satellites address a particular aspect of that newsworthy event, listing those involved, or

reconstructing the events leading up to the event. Satellites expand the information given in the Nucleus, and recycle that information, possibly from different perspectives or with a different purpose each time. There is often no logical connection between satellites other than that they all concern the same event (Iedema, Feez & White, 1994). The generic structure implements informational and interpersonal meanings in a conventional way to accomplish the certain rhetorical and communicative objectives (White, 1997a); actional and identificational meanings are related to the way the story author intends to communicate social practices via the text (Fairclough, 2003).

Table 3: Summary of Nucleus-Satellite Structure of 10-14-2003 Story and **Table 4: Summary of Nucleus-Satellite Structure of 10-12-2005 Story** is diagrams that illustrate the nucleus-satellite generic structure of the news stories. The two stories were printed in different years during Breast Cancer Awareness Month, and are representative both in terms of the way that KWCSF practices act as a source for cancer prevention texts, and that prevention texts are hybrids that contain personalizing information that constructs a public and official identity for the focal person. Both texts also contain “tell-and-sell” promotional content that contains informational content about cancer screening practices as well as a “sales pitch” to induce the reader to consume prevention services in the future. The 2003 story, which will be more thoroughly analyzed in the Profile story chapter later in the study, announces the promotion of a local nurse practitioner within the Harlan County Health Department to women's nurse health practitioner. The story satellites introduce the provider-recipient relation, reference KWCSF, the credentials of the nurse practitioner that allow her to do screenings, material resources including screening and surveillance technologies, educational materials and promotional incentives, and fees and insurance payments. It does not reference Medicaid nor Medicare, not does it focus on the technical aspects of screening. It does use most of the article as a vehicle to present a personalized and accepting face for the provider with whom most of the recipients will have a relationship as part of its “tell-and-sell” message.

The 2005 story focuses on a cancer screening recipient and her financial dilemma when her mammogram led to a diagnosis of breast cancer. Uninsured, the woman had no way of covering the costs of follow-up treatment. The same nurse practitioner from the 2003 story helps the woman access financial assistance through KWCSF. Again, KWCSF

Table 3: Nucleus-Satellite Structure of 10-14-2003 Story

Structure	Text
<i>Nucleus</i>	<p>Hensley <u>finds</u> satisfaction in job <u>helping</u> others</p> <p>She's <u>always</u> <u>considered</u> herself a "people person," and since graduating from high school, nurse practitioner Kelli Hensley <u>knew</u> she <u>wanted</u> to <u>be</u> in a profession where life enhancement skills <u>were</u> <u>taught</u> and <u>shared</u> with her fellow community members.</p>
<i>Satellite: Establishing Hensley's credentials</i>	<p>Hensley, of Baxter, <u>has</u> <u>been</u> able to advance in her medical career, with her most recent post <u>being</u> Harlan County Health Department's women's nurse health practitioner. On her newest job, Hensley <u>provides</u> health care services and counseling for families, particularly women. Cancer prevention tips <u>are</u> <u>shared</u>, along with counseling <u>concerning</u> the use of contraceptive methods, healthy living lifestyles and discussion and screening for sexually transmitted diseases.</p> <p>Hensley <u>said</u> she <u>loves</u> all aspects of her job, and <u>finds</u> satisfaction in <u>helping</u> families with their medical problems and planning, but with October <u>being</u> breast cancer awareness month, her attention <u>has</u> <u>lately</u> <u>turned</u> to Harlan County's need for better awareness <u>concerning</u> the deadly disease.</p> <p>"Over the years, I've <u>seen</u> an increase in the number of breast cancer patients," Hensley <u>said</u>.</p> <p>She worked three years as a registered nurse at the health department before <u>becoming</u> the agency's new women's health nurse practitioner.</p> <p>"You know, I've <u>never</u> <u>been</u> with a patient yet when they <u>have</u> <u>just</u> <u>found</u> <u>out</u> they <u>have</u> cancer, and I'm dreading that day, but I <u>hope</u> I <u>can</u> <u>reach</u> enough women through preventative education so that they <u>don't</u> <u>have</u> to <u>face</u> <u>battling</u> <u>this</u> <u>disease</u>," she <u>said</u>.</p>
<i>Satellite: Relating Hensley to Breast Cancer Awareness Month via mammograms</i>	<p>Hensley's friends and co-workers <u>describe</u> her as compassionate but relentless. She's <u>interested</u> in <u>helping</u> families when it <u>comes</u> to their medical inquiries, and she <u>shows</u> sympathy when <u>dealing</u> with patients in her office, but when it <u>comes</u> to <u>urging</u> women about the importance of <u>having</u> up-to-date cancer screenings, she's as tough as they <u>come</u>.</p> <p>"There <u>shouldn't</u> <u>be</u> any excuses for women <u>not</u> <u>have</u> mammograms or pap smears," she <u>said</u>. "Some <u>will</u> <u>say</u>, oh, it's <u>just</u> <u>too</u> expensive, or oh, my insurance <u>won't</u> <u>cover</u> it, or oh, it's <u>just</u> <u>too</u> scary. Well, here at the health department, we <u>provide</u> medical services on a sliding scale payment plan and we <u>try</u> <u>to</u> <u>be</u> as <u>soothing</u> and as <u>encouraging</u> as possible to our clients."</p>
<i>Satellite: The Sales Pitch for mammograms</i>	<p>The Harlan County Health Department <u>will</u> <u>be</u> <u>sponsoring</u> several activities during October to <u>promote</u> Breast Cancer Awareness Month. <u>According</u> to Gwen Turner, Community Health Nurse with the Harlan County Health Department, the first 20 women to <u>participate</u> in a cancer screening <u>will</u> <u>receive</u> a \$10 gift certificate to Food City. She <u>said</u> all participants <u>will</u> <u>also</u> <u>receive</u> free coffee mugs with several gifts inside, and <u>will</u> <u>be</u> <u>able</u> to <u>register</u> to <u>win</u> a free T-shirt or tote bag which <u>will</u> <u>be</u> <u>given</u> away each week.</p> <p>"<u>Having</u> a full-time nurse practitioner available at the Health Department <u>really</u> <u>helps</u>," Turner added. "And we <u>can</u> <u>also</u> <u>now</u> <u>bill</u> private insurances for services <u>provided</u> with the nurse practitioner. However, all services <u>are</u> <u>still</u> on sliding-fee basis and no one <u>will</u> <u>be</u> <u>turned</u> away because they have no insurance. Any woman age 40 to 64 year old <u>meeting</u> the income guidelines without health insurance <u>will</u> <u>qualify</u> for the Kentucky Woman's Cancer Screening Program, which <u>will</u> <u>cover</u> the cost of cancer screening services."</p>
<i>Satellite: Selling Hensley</i>	<p>Hensley <u>said</u> her goal as the health department's new women's health nurse practitioner <u>is</u> to <u>promote</u> well-being initiatives throughout the area and to <u>let</u> people <u>know</u> there <u>is</u> help if they're <u>faced</u> with a <u>potentially</u> <u>dehabilitating</u> disease like cancer.</p> <p>"I <u>love</u> my job. I <u>do</u> what I <u>do</u> because it <u>involves</u> <u>improving</u> people's quality of life and <u>reaching</u> out to them when they're <u>faced</u> with medical scares," Hensley <u>said</u>. "Also, I'm a woman, and I <u>know</u> there's a bond between women that's strong and true. I <u>feel</u> as if I <u>can</u> <u>really</u> <u>relate</u> to my patients, <u>discuss</u> their fears and show some understanding."</p> <p>While she <u>identifies</u> with her women patients and daily <u>grows</u> more <u>concerned</u> about the cancer rate in Harlan County, Hensley <u>remains</u> <u>dedicated</u> in <u>making</u> sure the women with which she <u>comes</u> in contact (whether on a professional or personal basis) <u>makes</u> time for cancer screenings.</p> <p>"Life <u>is</u> <u>too</u> precious and exciting <u>just</u> to throw away," she <u>said</u>. "The earlier cancer <u>is</u> <u>detected</u>, the better a patient's chances <u>are</u> of <u>not</u> <u>only</u> <u>surviving</u>, but <u>beating</u> the disease and <u>returning</u> to a normal life. I <u>can't</u> stress <u>enough</u> how valuable cancer screenings <u>are</u>. You <u>may</u> feel <u>perfectly</u> fine, but below the surface, there <u>could</u> exist a lump in a woman's breast that <u>is</u> <u>only</u> detectable though a mammography. So, even though a person <u>may</u> <u>not</u> <u>have</u> any symptoms, annual cancer screenings <u>can</u> mean the difference of a possible death sentence of a good life prognosis."</p>
<i>Coda</i>	<p>For more information or to <u>schedule</u> a cancer screening, <u>call</u> 573-4820 or 573-3700.</p>

Table 4: Nucleus-Satellite Structure of 10-12-2005 Story

Structure	Text
Nucleus	<p>Breast cancer screenings <u>offered</u> at health department</p> <p>A Clover Fork woman <u>sought</u> assistance through the Harlan County Health Department with payment help for breast cancer treatment.</p>
Satellite: Elaboration of Skidmore's dilemma-links mammogram to discovery of a potentially disruptive illness	<p>Betty Skidmore <u>went</u> to the health department last December for a mammogram <i>when</i> a knot <u>was</u> discovered.</p> <p><u>When</u> the health department <u>finds</u> any problems or abnormalities, their patients <u>are referred</u> to the proper health care physician.</p> <p>"The knot <u>was</u> suspicious, <i>so they sent me to the hospital,</i>" said Skidmore. <i>"Right away, they wanted me to have a biopsy. I <u>was then sent</u> back to the health department to <u>get</u> the papers <u>signed</u> to <u>have</u> the biopsy."</i></p> <p><i>Skidmore was diagnosed with breast cancer.</i></p>
Satellite: Connecting Skidmore to KWCSF through HCHD practices	<p><i>She <u>was then sent</u> back to the health department where she <u>was introduced</u> to women's health nurse practitioner Kelli Hensley, who <u>has been</u> a practitioner for two years and <u>has been involved</u> in women's health around five years.</i></p> <p><i>Hensley <u>told</u> Skidmore about the Kentucky Women's Cancer Screening Program (KWCSF).</i></p>
Satellite: Contextualizing KWCSF history and requirements	<p>Since 1990, the KWCSF of the Kentucky department for public health has provided breast and cervical cancer screenings and follow-up diagnostic services throughout local health department's, and the Harlan County Health Department has conducted several hundred cancer screenings each year since that time.</p> <p>Through the health department, women can receive a breast exam and mammogram, a pelvic exam and a pap test. If any abnormal results are found, the women may be eligible for Medicaid coverage and treatment through KWCSF.</p> <p>In order for the program to pay for treatment, the following criteria must be met: You must have an initial screen at the health department, be 21 to 64 years of age, be income eligible, have no other third party payer source, have a social security number, not be housed in a public institution, be a resident of Kentucky and be a U.S. citizen or qualified alien..</p>
Satellite: KWCSF requirements naturalized	<p>Ultimately, Skidmore met these requirements.</p> <p><i>"Kelli immediately got on the phone and got this set-up to where I could get my treatment paid for," said Skidmore. "It was surprising to me. I had no idea about this program."</i></p>
Satellite: Elaboration of the treatment process	<p><i>After Skidmore's biopsy, she was advised to either have her breast removed or have treatments.</i></p> <p><i>Skidmore then chose to go to Saint Joseph's in Lexington, where she had a lumpectomy.</i></p> <p>She then underwent four chemotherapy treatments in Lexington and 33 radiation treatments in Corbin, which were also paid for by the program.</p> <p><i>"It sure made a difference knowing that I could do this and not have to worry about the financial part," said Skidmore. "A lot of people don't know about this. It's wonderful."</i></p> <p><i>Skidmore added that going through the treatments is hard enough, and that it's a great thing that this program is there for women to get the care they need and deserve.</i></p> <p>Skidmore will be going to both Lexington and Corbin this month for follow-ups.</p>
Satellite: Program Endorsements and Benefits	<p><i>Skidmore said that she has never been treated as nice as she was at the health department, and that the nurses there have even called and checked on her. She went on to say that it's nice to know that people really care.</i></p> <p><i>Roy Skidmore, Betty Skidmore's son, is pleased with the payment help that his mother received.</i></p> <p><i>"I'm thankful to know that the benefit was there for my mother," said Roy Skidmore. " She had enough stress with the ordeal, and it was nice to know that the program was there to lift the financial burden."</i></p> <p><i>Hensley said that this is a great program.</i></p> <p><i>"I think if it wasn't for the program, a lot of women wouldn't get the care they need," said Hensley.</i></p> <p>The health department makes sure that patients are followed closely to see that they get all of the proper follow-up care.</p> <p><i>Community health nurse at the Harlan County Health Department, Gwen Turner, is thrilled with the program.</i></p> <p><i>"It's one of the best kept secrets in Harlan County," said Turner.</i></p>
Satellite: Sales pitch and incentives	<p><i>Turner also wants women to know that October is Breast Cancer Awareness Month, and that they are encouraged to receive cancer screens at the health department.</i></p> <p><i>"Every woman that has a cancer screen this month will receive a free mini tote filled with incentives, such as a</i></p>

	breast care diary, emery board, forget-me-not flower seeds and mints," said Turner.
	All women who get cancer screens at the health department will also be registered to receive a large nylon tote with a make-up case, pedometer and flashlight keychain.

social practices act as a major generic source for organizing the story's narrative. Features of the program's practices are recontextualized as part of a drama in which the woman is given her diagnosis, experiences the trauma of getting positive results and needs treatment, but not being able to pay for it. The nurse practitioner is able to provide a solution via KWCSF and both the woman and her son offer endorsements of the program and the health department. A similar sales pitch concludes the story, again recommending women pursue screening and not allow expense to inhibit them.

Figure 3: Network of Practices Specific to Cancer Screening takes diagrammatic aspect another step by treating the two nucleus-satellite structures much like a pair of ego networks in social network analysis. The stories both have two persons and an organization in common and the satellites were treated as nodes in the network. Incidents and activities as reported in the satellites were extracted and a small 2-mode network was developed that linked story activities to the story date. The network was further reduced to a 1-mode network that simply tied events to each other. The dark blue lines in the diagram represent links between events that were found in both stories, while the red lines link events that were unique to a single story. The both stories used satellite information to elaborate practitioner and patient eligibility to participate in KWCSF. The practitioner was personalized for the reader in both stories. Also, a sales pitch that included mention of incentives was made and mention was made of help paying for services. The difference in the two stories was the change of focal character from introducing and personalizing the practitioner to describing a health dilemma experienced by a patient and offering KWCSF practices as the solution. The 2005 story offers a concrete example of the "collectively fashioned, mutually recognized, and endlessly rehearsed predicaments of attempting to improve health in a world of apparently unhealthy enticements provide a template for our larger predicament" described as part of the ritual of health promotion by Crawford (2000).

An Example From the Environmental Stories

Figure 4: Network of Practices Specific to Mine Accident Reports translates the

Figure 3: Network of Practices Specific to Cancer Screening

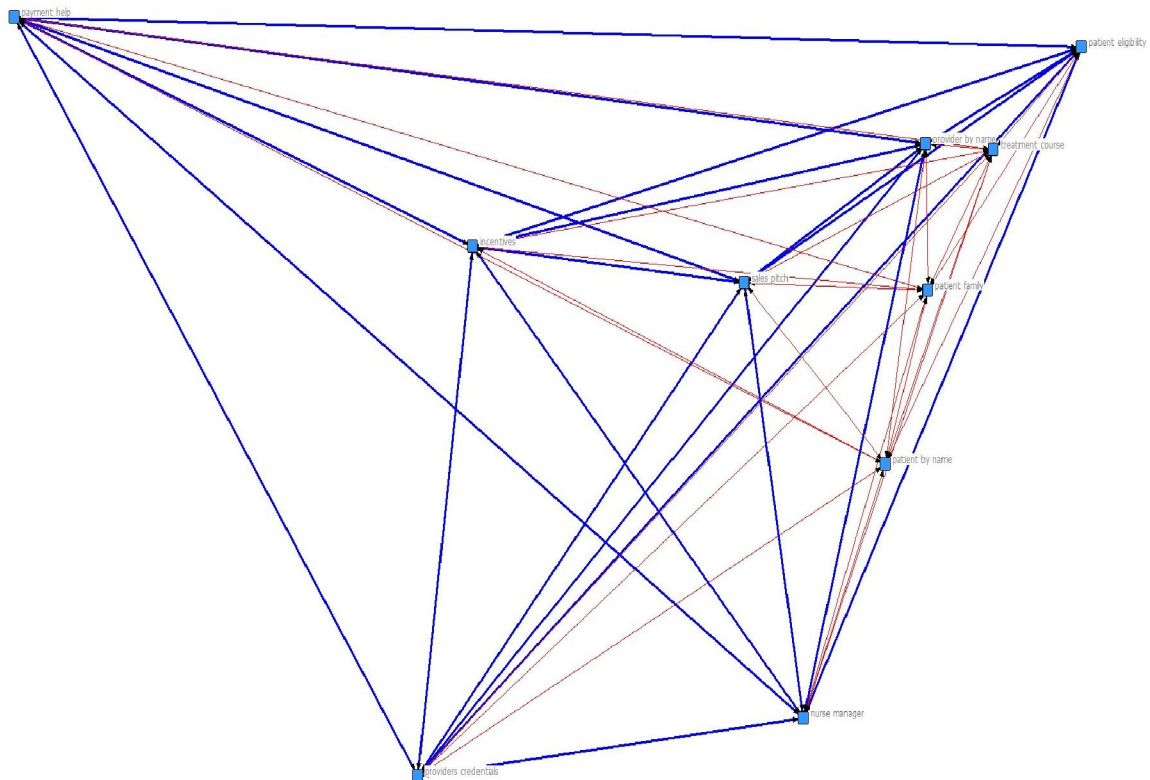
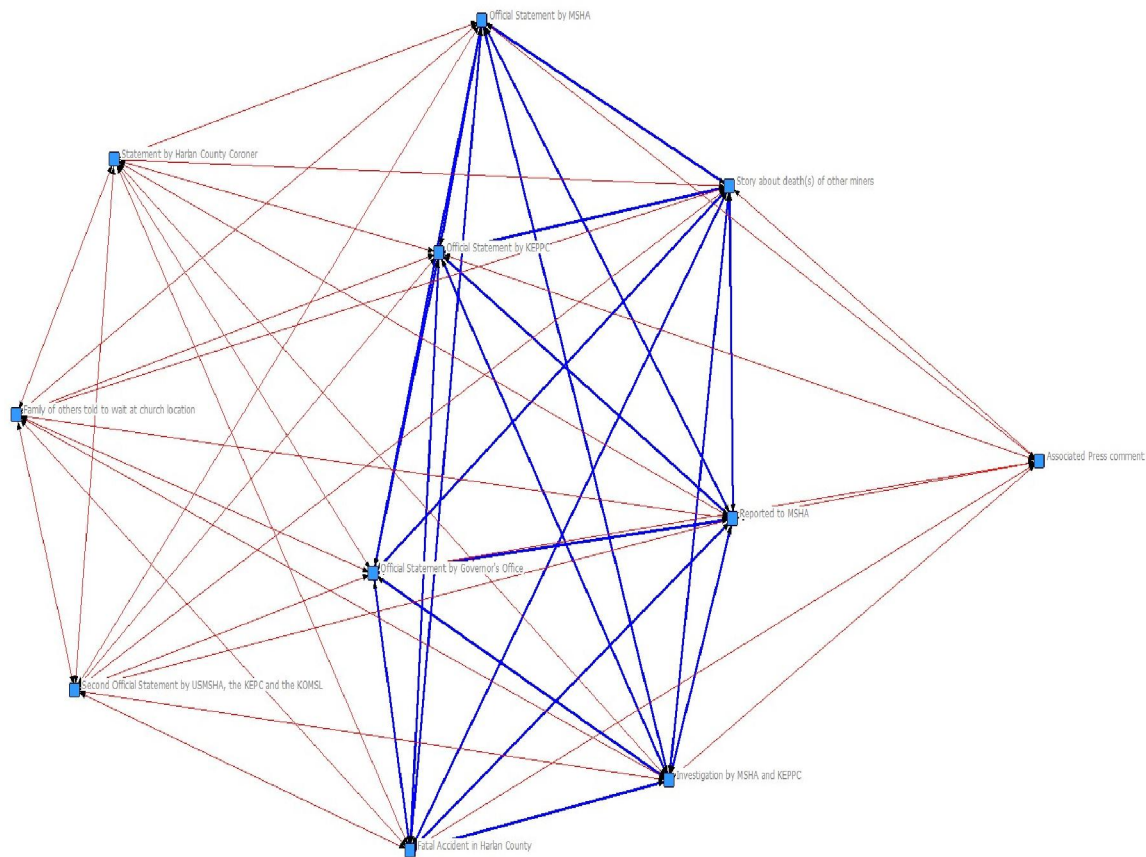


Figure 4: Network of Practices Specific to Mine Accident Reports translates the practices into an actual network representation of actional types that are part of the genre of news used to report news of mining deaths in the *Harlan Daily Enterprise*. Working with the stories from 4-22-2006 and 5-22-2006, which report on the death of a single miner in one story and the death of six miners in another story, each story was deconstructed to lift out the title, initial qualitative analytic category used to develop network links among actors and organizations, the actors listed in the story and the organizations listed. Incidents and activities as reported in the stories were listed as well. A small 2-mode network was developed that linked story activities to the story date, and this network was further reduced to a 1-mode network tying events together. The dark blue lines in the diagram represent links between events that were found in both story, while the red lines link events that were unique to a single story. The left side of the diagram involves events unique to the 5-22-2006 story and the event ion the right side of the diagram was unique to the 4-22-2006 story. Both stories included a description of the fatal mining accident, which described where the accident occurred, who owned the

Figure 4: Network of Practices Specific to Mine Accident Reports



mine, the name(s) of the miner(s), how the miner or miners were killed. Both stories also included mention that the accident was reported to state and federal officials, acknowledgement of an official investigation of the accident by state and federal officials, statements by the government agencies involved, a statement by the governor of Kentucky, and reference to other miners killed in similar accidents in recent months.

The stories typify the use of official sources for news reporters. There is a careful avoidance, both by spokespeople giving statements and by the newspaper, of mention of who is culpable for the accident. Stories may include reference to a particular mine's history of being cited for safety violations, and in some cases, the parent corporation owning the mine and the mine company operating it may also be discussed in terms of its safety history. Still, the issue of who is legally at fault is still ambiguous at the time the initial story is reported and the mention of an official investigation marks the beginning of the legal process that is used to assign blame for the deaths beyond the immediate conditions of the accident itself. Since multiple miners were killed in the accident

reported in the 5-22-2006 story, discussion of the way officials treated the families of the miners, when information was given to them and how it was delivered, was an important element of the story. Reference to previous accusations of official mishandling of information and inconsideration of family concerns was also brought into the story.

Because the accident in the 5-22-2006 story also had a survivor, there was a good deal of hearsay evidence about the events leading to the accident reported by quoting the brother of the surviving miner. This information can be further decomposed into an event sequence related to the accident, illustrating how the survivor did some things differently such that he was saved and the other two miners with him were killed. The activities engaged in by two miners that lead to their deaths are elaborated just enough so that they indicate what saved the survivor. This hearsay evidence constitutes an additional story projected into the main news story, micro-analyzing the moments leading up to and into the early moments of the accident from one miner's perspective, changing the temporal scale of reporting and providing the reader with so sense of what took place onsite. The overall effect is to increase the sense that a minor decision at some point during a disaster situation can make the difference between life and death.

Cliques and the Basis of Social Worlds

From the examples above, it would appear that the use of direct and indirect quotations from within the stories, identifying persons referenced in the text and their organizational affiliations, and qualified by the categorical content of the quotations, extracts affiliations that reflect the intertextual positioning of social relations represented in the texts. Their affiliations are based on the perceived shared foci among actors and organizations related to the social practice activities and issues represented in the story. A network diagram of the relationship between various organizations represented in the 2006 environmental stories appears in **Figure 5: 2006 Stories: Organizations by Categories**. By marking organizational actors in red, we see a sub network emerge among a set of organizations. The sub-network constitutes a kind of social circle (Simmel, 1955; Kadushin, 1968; Kadushin, 1976) that is at least partially recognized by the way source information is gathered and reported upon. The social circle emerges based primarily on co-affiliations to the directly (and indirectly) quoted sources available in the mine-death related stories. Because the actors and organizations involved in the

It is important to recognize that directly quoted material is still only a representation of what was said, not simple, literal reproduction (Fairclough, 2003). Reporters select among source quotes, choosing to use some and not others – they typically draw on official and expert sources first and use community voices selectively for color as exemplars (White, 1997a; 1998). They also frame references through how they are introduced into the text as either supported or unsupported, approved of or disapproved of. The resulting cohesion, or lack thereof, among social actors represented through affiliations to a given story or story topic category is more about how the reporting news

organization “bricoleured” the source materials to create a coherent story than it is about existing cohesion in a community. The best one can hope to do from a close reading of the stories is to identify the represented linkages and understand the possible ideological implications of the linkages given the framing used to make sense of events and information in the story.

In the diagram in **Figure 5**, there is a core group of interactants, mainly made up of families of the miners involved and the lawyers who came to represent them in litigation that followed after the accident. There are additional actors surrounding the core made up of federal, state, and county officials charged with investigating the accident. To the left are mining companies where deaths occurred and at least one expert organization that commented on the dangerousness of mining practices being deployed during this time frame. One could argue that the closer one is to the core group, the less conflictual is the relationship to the families of the deceased or injured miners. Further analysis would be necessary to completely clarify the relationships and draw lines among the signs, but the point here is to 1) illustrate how sub-groups of nodes in the networks act as the basis for sub-world activities in a larger network, or social world; 2) many of the subgroups include conflict, but that this is not necessarily always true; and 3) cohesion, or lack thereof, among social actors represented through direct or indirect references in a story are more likely to be about how the reporting news organization used source materials to create a coherent story than it is about existing cohesion in a community.

The analysis of social practices and the resulting interactional networks suggests that clique analysis of the health story and environmental story organizational networks can provide a way to examine the ideological implications of the social practices depicted in the news stories, and possibly find clues to community attitudes about the two cultures of action affecting cancer prevention. The next section develops this idea by adding a status attribute to the analysis based on organizational affiliation to the intertextual positioning networks and then examining the structure of the clique relations based the composition of the various organizational ego networks. Specifically, I examine how different groups and organizations of varying statuses are tied to the Harlan County Health Department (HCHD), the American Cancer Society (ACS), and the Harlan Appalachian Regional Hospital (HARH). I also construct a composite network of environmental groups around

the Kentuckians for the Commonwealth and examine how those groups are tie to the Harlan County Fiscal Court, the county government entity most involved with the sewer, water quality, and solid waste disposal stories.

Intertextual Positioning and Cliques in the Two Cultures of Action

In this section, I continue to examine themes of cohesion and social structure related to the two cancer prevention Cultures of Action as represented in the Harlan Daily Enterprise stories. As previously discussed, an important issue relates to the nature of the source to whom the material is attributed. The concern is with the nature and status of the social actor(s) from whom/which the externally sourced statements are said to be derived. This is an area which has been widely covered in the literature under such headings as "attribution", "direct and indirect speech", "intertextuality" and references the earlier discussion of Bakhtin's notion of "heteroglossia" (White, 2001). Intertextual positioning is brought into play when a writer/speaker chooses to quote or reference the words or thoughts of another, and, in doing so, indicates that these words are in some way relevant to the current communicative purposes. Thus the most basic intertextual evaluation is one of implied 'relevance', as judged by the author's choice to select the material for inclusion in the text.

Intertextual positioning is concerned with uses of language by which writers/speakers adopt evaluative positions towards what they represent as the views and statements of other speakers and writers (White, 2001). Effectively, intertextual positioning is at work when a writer/speaker chooses to quote or reference the words or thoughts of another. Intertextual positioning attributions can be seen as dialogistic from several perspectives. The speaker/writer appears to have engaged in some manner with the source by quoting them, at least in terms of the source's socio-semiotic position as expressed in another text. This kind of intertextual positioning is essentially retrospective. The speaker/writer refers back to what has been said, written, or thought previously. White (2001) argues that such intertextuality can also be prospective in that attributions can act to position the speaker/writer's current utterances with respect to anticipated responses from actual or potential interlocutors. This is particularly evident when expert voices are used to affirm the value of a particular choice or object and the text then makes reference to when and/or where the choice or object is available. For example, a common pattern in

American Cancer Society-related stories is for the writer to quote the a person who has benefitted from involvement with an ACS program, then the location and contact information for the program is given later in the story.

In chapter 1, I had referred to Florence Passey's work on commitment to social movements (Passy & Giugni, 2000, 2001; Passy, 2002), which had shaped the way I asked questions of coalition members when originally gathering data on the coalitions themselves. Passey's use of the Lifeworld concept to understand how adherents come in contact with and subsequently stay or leave social movements assumes shared social interests and practices in the context of one's important social ties, at least for local time members of social movement organizations. It is typical, according to Passey and Giugni (2000; 2001) for actors to form ties that bring them into movements, but also that provide other Lifeworld supports that give them continued incentive to stay. Feld (1981) developed a theory of social organization based on the notion that people typically organize much of their social activity based on shared foci of attention related to social practices. He defined social context as consisting of a number of different foci and individuals whereby each individual is related to some foci and not to others. Group activities, according to Feld, are organized by a particular focus to the extent that two individuals who share that focus are more likely to share joint activities with each other than two individuals who do not have that focus in common.

Simmel (1955), who is attributed with the early formulation of this theory, saw collective attitudes as emergent in social circles:

The development of the public mind shows itself by the fact that a sufficient number of circles is present which have form and organization. Their number is sufficient in the sense that they give an individual of many gifts the opportunity to pursue each of his interests in association with others. Such multiplicity of circles implies that the ideals of collectivism and individualism are approximated to the same extent. On the one hand the individual finds a community for each of his inclinations and strivings which makes it easier to satisfy them. This community provides an organizational form for his activities, and it offers in this way all the advantages of group-memberships well as of organizational experience. On the other hand, the specific qualities of the individual are preserved through the combination of circles which can be a different combination in each case (p. 162-163).

Unruh (1980) argued that Chicago School symbolic interactionism developed the idea

of social worlds in a manner that is very similar to the social circles concept. According to Unruh, symbolic interactionists like Park and Cressey tended to associate specific geographic locales with social world activity. Later work by Shibutani (1955) merged Meadian Interactionism with the early Chicago perspective on social worlds and was tinged with images of process, emergence, fluidity, and negotiation. He referred to "universes of discourse" as the determinants of social world boundaries, with the boundaries of social groups being formed more by the extent of effective communication. Such a perspective can complement Communication Infrastructure Theory, grounding it in local processes of shared social practices and the discourses that accompany them. For my purposes, the point is to recognize the ways that overlapping subnetwork structures are built up around shared social practices. I want to take advantage of this idea to understand the social structures that emerge from the newspaper stories in the Harlan Daily Enterprise, given an understanding as well that the referenced sources appearing in the stories are intertextually positioned by the story authors. The structures, then, are a selective representation of community structure, built up to describe and frame socially disruptive events, constrained by the limits of local newspaper reporting and the competition between different community voices for attention from reporters. One way to examine the process is to create a set of codes to order organizations by their status and use that status attribute to analyze the competition of clique structures in the network data.

An important issue relating to the nature of the source to whom the material is attributed involves how the story author(s) specify who source references are. White (1997b) argues that this concerns the nature and status of the social actor from whom/which the externally sourced statements are said to derived. One assumption is that, because the source is cited at all, the author(s) have decided that the source is in some way relevant to the communication purposes of the story. White (1997b) further develops the work on social actors by Kress and Van Leeuwen (1996) to make distinctions about how sources are represented in texts including whether or not the source and the views they hold are endorsed or not by the author(s), whether the author(s) takes any responsibility for the source's views, whether or not the source is human or non-human, identified by name or not, identified as a specific person or group or

generically typed, a single individual or grouped in some way, and whether the source has some kind of authority, status or power. **Table 5: Coding Scheme for Source**

Specifications of Status displays the coding classification I used to organize the data set by status and **Figure 6: Organizational Network by Status (Nine status codes)**

represents the network of organizations from the seven year population of stories using colors and code labels to mark nodes in the network. Environmental groups and families ended up both being colored grey by Ucinet's default coloring scheme, so I added the code labels to further clarify which nodes belonged to which status. For the most part, there were more families ("grey", "9") than environmental experts ("grey", "3"), especially in the cluster of organizations below and to the right of the center of the diagram. As could have been predicted by earlier discussion of the use of official sources by reporters, government organizations ("red") were the largest single group of nodes in the diagram. Medical organizations ("magenta") tended to cluster in the upper right of the diagram, while corporate organizations ("dark blue" tended to be at the center line and below.

The first six codes in **Table 5** can be thought of as "high status" while the last four are related to "low status". Using this binary distinction to indicate high and low status organizations further clarifies the emphasis on high status sources in the organizational make up of the story set. **Figure 7: Organizational Network by Status (Binary codes)** segments the network in terms of the of the two statuses and suggests that high status voices and the practices they use to order the social world dominate the social landscape that appears in the local news in Harlan County.

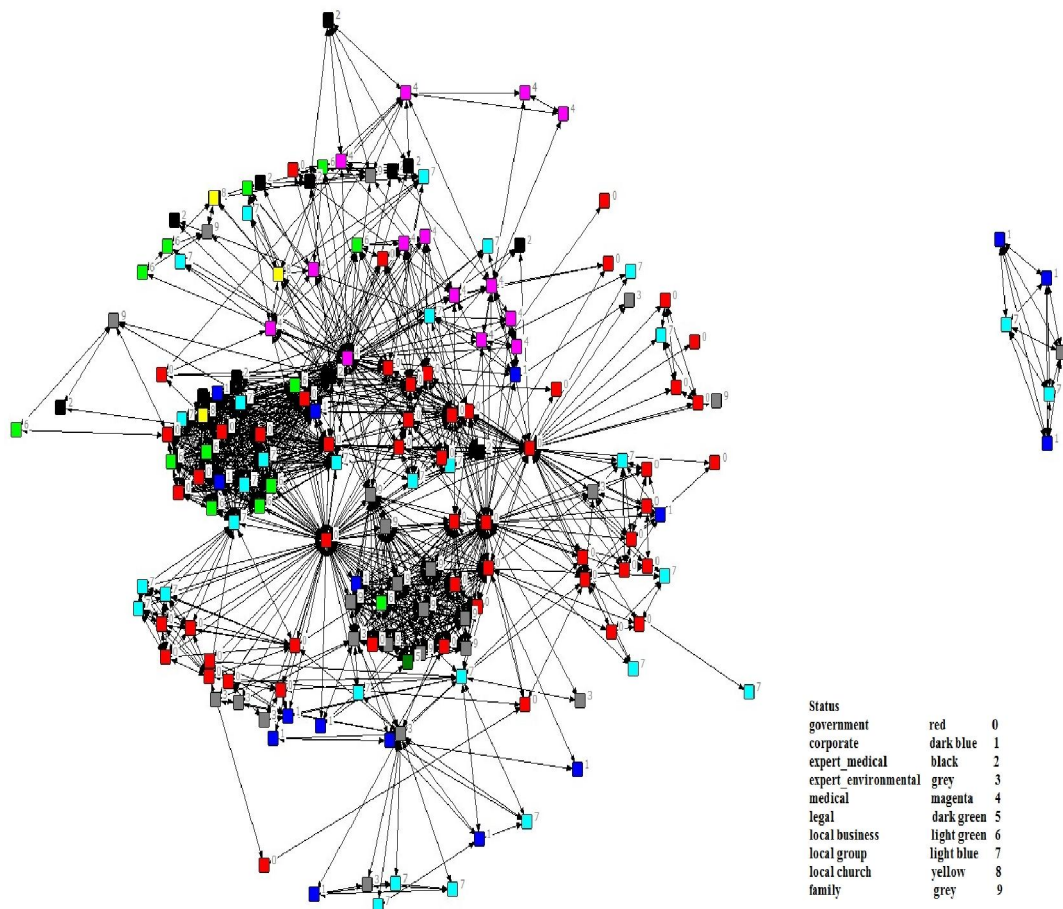
Health Organization Cliques as Further Specification of Social World Segmentation

A clique is a sub-set of a network in which the actors are more closely and intensely tied to one another than they are to other members of the network (Hanneman & Riddle, 2005). Cliques can be as small as a pair of ties forming a dyad, though in this study, I analyzed clique structures based on triads of larger numbers of ties to reduce the number of possible combinations. The organization network from the seven year story sample still yielded seventy-four cliques of three or more organizations. Cliques have been associated with the building up of social circles, and larger social world structures in the network literature (Kadushin, 1976; Feld, 1981; Crossley, 2012), so a clique analysis of

Table 5: Coding Scheme for Source Specifications of Status

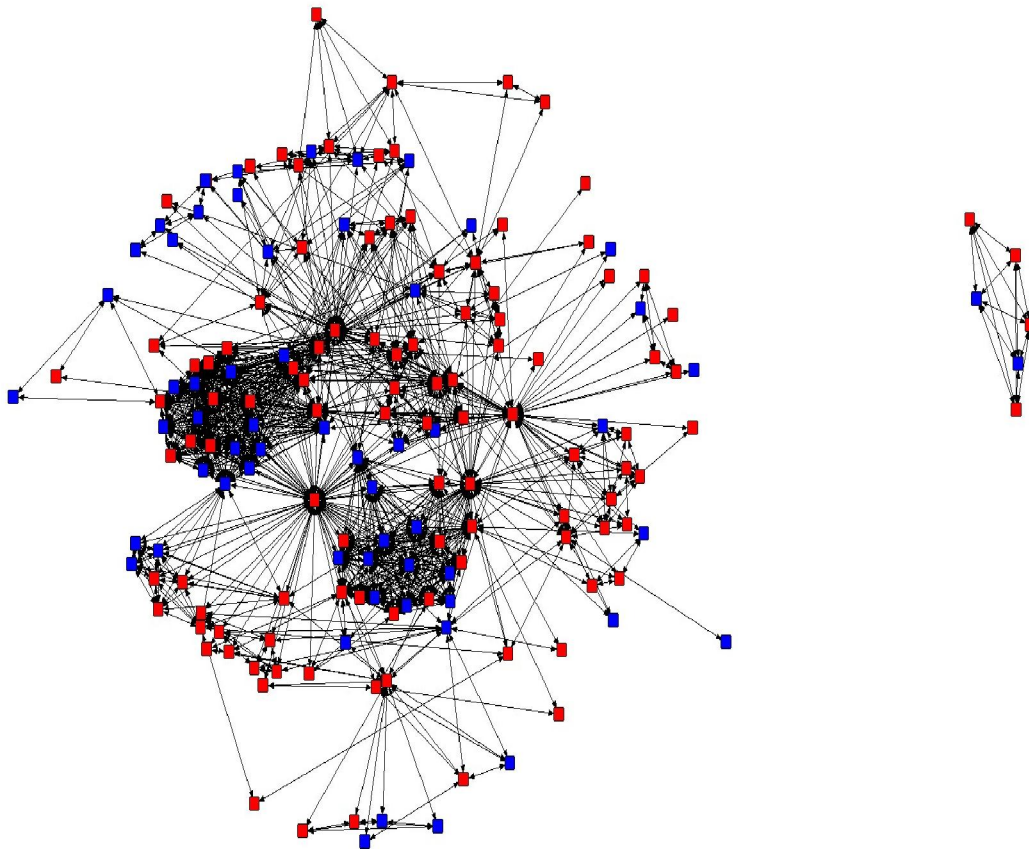
Coded as	<i>Stat1</i> code	<i>Stat2</i> code
<i>High</i>		1
government	0	1
corporate	1	1
expert_medical	2	1
expert_environmental	3	1
medical	4	1
legal	5	1
<i>Low</i>		2
local business	6	2
local group	7	2
local church	8	2
family	9	2

Figure 6: Organizational Network by Status



the organizational network from the seven year story population can allow some micro-examination of the types of ties that are implied or explicitly stated to exist among

Figure 7: Organizational Network by Status



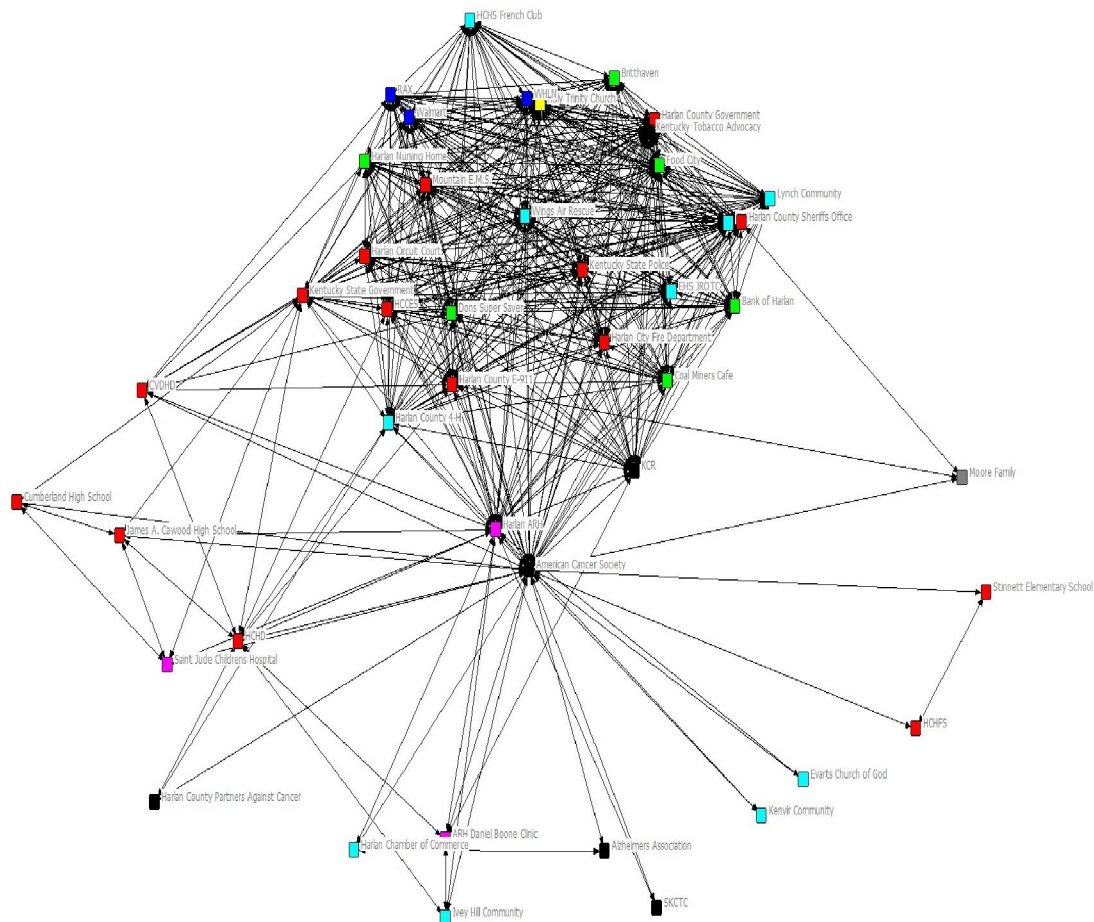
different organizations, particularly in terms of whether conflicts concerning issues and positions are stated to exist and how those are represented.

Figure 8a: HCHD Cliques displays organizations tied to the Harlan County Health Department (HCHD). The local cancer prevention coalition, Harlan County Partners Against Cancer, is a black node located above and just left of center. I chose to label HCHD a government organization because of its appearance in the stories frequently as a health code enforcement agency. That role is particularly apparent in the environmental stories, where it appears as a potential source of sanctions for community members if they fail to sign on to sewer system and solid waste plans. For the most part, HCHD appears in relation to a number of other government agencies and organization in the stories, with Harlan ARH and one of its local clinics being the only medical organizations closely tied to its activities.

Figure 8b: ACS Cliques represents the clique set associated with the American Cancer Society (ACS). ACS has a number of ties to government organizations as well as

The third Early Detection and Screening Advocacy COA organization, Harlan Appalachian Regional Hospital (HARH), is diagrammed in relation to cliques and status in Figure 8c: HARH Cliques. What is most interesting in the diagram is that it subsumes most of the clique structures depicted in the other two network structures. As the local

Figure 8b: Health Stories: ACS Cliques



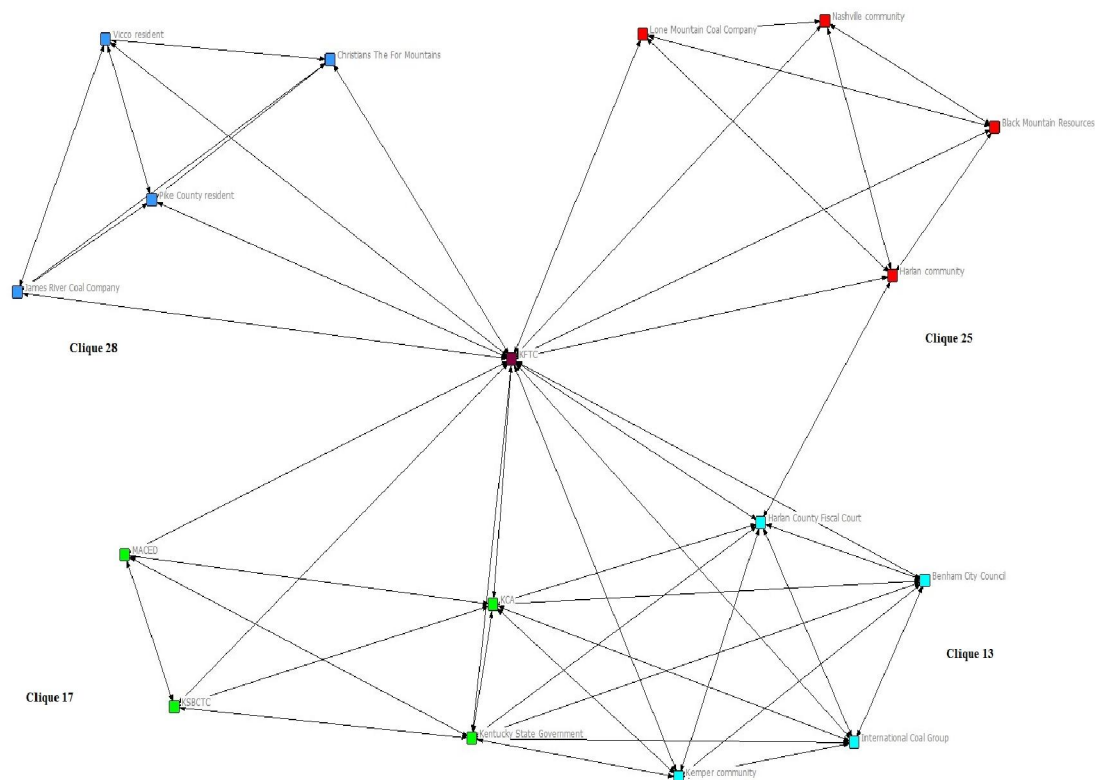
hospital, operating with several satellite clinics around the county, HARH appears repeated in relation to health-related stories. The lower left-hand cluster of magenta colored health organization nodes are historically important because they represent the legacy of names that hospital and its parent corporation have shared since its inception in the 1960s. The organizations are referred to in a story about the anniversary of the hospital and are also part of specific efforts by the story to position HARH in relation to the county's coal heritage, as well as to suggest the hospital has an important place in the economic well-being of Harlan County. Many of the other nodes magenta colored health care organization nodes are HARH satellite clinics from around the county. St. Jude's Children's Hospital appears in two cancer stories related to young people who are also cancer survivors. I will analyze one of the stories in more depth in the later Profile story chapter. For now, it is important to mention only that, like the cancer prevention stories from women's magazines that McKay and Bonner (2002) analyzed, there were stories

Environmental Organization Cliques

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Finally, **Figure 9b: KFTC Cliques** illustrates community organizational ties related to Kentuckians for the Commonwealth, arguably, the most important counter voice to coal surface mining in the region. What stands out in the network representation most vividly is the number of light blue nodes representing communities from around the county. Typically local community actors are situated in stories that are criticizing mountaintop removal and damage it has done in the region by locating them in a particular local community. This means their specification as a source is also likely to be ambiguous at the organizational level unless they specifically associate themselves with KFTC in the story. Analysis of the story content across the several stories where KFTC is mentioned suggests that the governmental agencies tied into this clique set, as well as FACES and the corporate coal company organizations identified by the dark blue nodes

Figure 9b: KFTC Cliques



in the network are all in conflict with KFTC. In fact, this is the only clique set of the five that makes explicit reference to conflict aside from some disagreement with funding and regulatory practices related to sewer system sign-ups in the fiscal court stories. Across the story set as a whole there was little explicit reference to conflicts among parties involved, and most of that was resolved by the story author(s) by deferring to official sources and their positions.

Interpretation and Conclusions

As the network diagrams show, the HDE stories draw heavily on high status sources to depict relationships related to the two cancer prevention COAs. Much of the historical conflict related to the destruction of water quality and the spread of sewage and waste pollutants in local waterways related to surface mining are mentioned, but glossed as an inevitable consequence of coal mining's place in local community economic development. The reliance on official sources in the HDE stories tended to submerge community conflict and mystify issues related to who is responsible for the damage by focusing on technical issues of system financing and enforcement of local regulations

related to signing on to and using the system. Oppositional voices are not typically present in the stories and no mention at all of coal industry culpability for damages or responsibility for the cost of repairs is explicitly stated. Severance tax dollars as a source of revenue for repairs are lauded as valuable, but no historic connection is drawn to the reasons for severance taxes in the first place nor is there discussion of whether sewer system repairs are an appropriate severance tax expenditure.

The apparent community solidarity depicted in the HDE stories about using severance tax dollars for sewer system repairs is an example of an official source “winning” the competition to get its message heard at the expense of a lower status perspective. According to KFTC’s official position posted on their website, Kentucky currently subsidizes the coal industry with over tax credits, tax expenditures or direct support, in excess of \$97.4 million dollars, including \$26.7 million that comes from the coal severance fund (KFTC, 2007). The Legislature and Kentucky’s Governors have controlled how severance tax dollars are distributed, supporting use of “line-item” allocations and state bureaucratic programs to direct and restrict the usage of severance funds, as well as to make appropriations from the portion designated to be available for the local communities. Coal severance funds have often been returned to the coal industry by requiring counties to spend severance funds to maintain “coal-haul roads”, which are the same roads used and destroyed by the coal companies. In addition, Kentucky’s Worker’s Compensation Fund, over-burdened by mining caused claims and underpayment by coal companies, is annually propped up by a \$19 million dollar “off the top” transfer of severance funds (KFTC, 2007). The use of coal severance tax funds to repair water and sewage systems was a regular complaint made by local KFTC members I talked to as another example of the coal industry’s influence trumping local voices as to how severance tax dollars should be used.

The stories in the HDE sample reference HB 1, then governor Ernie Fletcher’s energy plan bill from 2007, which was signed into during the 2007 Second Extraordinary Legislative Session. HB 1 uses coal severance funds to subsidize a new wave of coal related industry – the conversion of coal to a gaseous or liquid fuel – providing rebates for the coal industry of up to 80% of paid coal severance taxes that would come off the top of the severance fund before any calculations are made to determine how much is

returned to the counties (KFTC, 2007).

Public hearings and forums related to HB 1 and other mining legislation are typically depicted as ineffectual in the HDE stories. Community members are quoted and their grievances partially aired in news stories, but for the most part are represented as frustrated, emotional, and ineffectual. Counter stories about rallies by the coal industry and miner support for pro-coal legislation are depicted as if they are an equally distributed opinion within communities without any actual evidence of what the distribution of attitudes for and against the legislation actually are.

The Early Detection and Cancer Screening Activism COA

In many ways, the Early Detection and Cancer Screening Activism COA and the stories related to them feed the perception that the community enjoys greater solidarity around health-related issues than is possibly there. None of the stories (or the organizational members I talked to firsthand) embraced serious questioning of the coal industry about its impacts on local health. I saw no discussion in the HDE stories of research from the same time frame from which the stories were drawn of a growing body of research linking mountaintop removal mining practices to consistently poor health outcomes, including increased rates of cancer, in coal producing counties of Appalachia (Hendryx, 2011; Hendryx & Ahern, 2008). The emphasis was consistent across the board with what others have found in the Early Detection and Cancer Screening Activism COA (King, 2006; Klawiter, 2008; Ehrenrich, 2009). Sales pitches for fund-raising activities and the promotion of specific programs are consistently tied together with positive, upbeat stories about survivors or volunteers. Although I found no accounting for the extent to which funds are returned to local communities in Harlan County, there were some reports lauding the community and its volunteers for raising large amounts of funds. As with the coal severance tax practices, there were no efforts to question the continued extraction of funds from local communities which appear in all seven years of stories and there is never a breakdown of how those dollars are spent supporting community members with cancer or their families.

Though there is one story about using KWCSF to aid a local woman in getting treatment for her cancer, additional discussion of how low income community members also need support paying for transportation, meals, and other expenses of cancer

treatment are not discussed. As mentioned earlier, consistently, across counties, fund-raising aimed at creating local funds for transportation and other personal supports for screening recipients diagnosed with cancer and in need of continuing, repeated treatments are never discussed in stories in local media. As a matter of fact, discussion of ACS and KWCSF practices appear to gloss many additional financial issues that arise for those being diagnosed with cancer including loss of livelihood and a general failure to provide health insurance for much of the local population that affect regional issues related to health disparities. Combined with the silence concerning environmental dangers related to mining and a repeated focus on simplistic, positive messaging about cancer prevention fits the description of local media representation of cancer prevention as a kind of “Brightsiding” (Ehrenreich, 2009). Ehrenreich has complained that when she was diagnosed with cancer several years ago, her experiences with mainstream cancer prevention involved an unrelenting message that one had to be cheerful and accepting. She was even told that someone would not recover unless they remained positive. She experienced this as a form of trivializing of her condition. Ehrenreich states she felt that rosy affirmations distract us from more important issues about environmental carcinogens, insurance system inequity and toxic treatments for cancer patients. These affirmations are typically associated with advertisements for breast cancer teddy bears, promotional “incentives,” products in pink ribbon promotions, inspirational slogans, and politically correct language. Ehrenreich insightfully points to the ways larger failures of Neoliberal economic policy, such as the many economic bubbles that have burst in recent years causing recessions and economic collapse, are supported by the continual emphasis of “investor confidence” and our obsession greater productivity without additional supports or returns for our efforts. Her observations resonate with Peltz's (2005) descriptions manic psychological defenses used to minimize one's suffering and dependency on others discussed in Chapter Two.

Ehrenreich's complaints also overlap with the earlier discussions of Samantha King's (2006) work on Pink Ribbon, Inc. We see repeated efforts to use certain corporate-sponsored forms of philanthropy to continue a broader process that insulates markets and decisions about markets from public debate. Individual, consumer-based forms of philanthropy are praised as effective solutions to complex social problems, effectively

painting those community members who engage in them as consumer-citizens (King, 2006). Consumer consumption practices are understood to drive both economic interests and charitable behavior. Participating organizations build a virtuous identity as corporate citizens by associating with promotional activities and through charitable giving. What is left out is the distancing from more controversial themes related to the region's disputes over environmental and economic injustice.

Because these positions are embraced by the official sources most drawn upon in mainstream media, they have appearance of being widely accepted and common sense in nature. In-depth discussions that would require communities to deploy reflective judgment to understand what are actually intractable, ill-formed problems are consistently omitted. Instead of providing a forum for well-rounded discussion, newspapers offer a tell-and-sell promotional culture that purports to offer "tips" and rules of thumb, packaged with repetitive personal endorsements; they do not offer the quality information necessary to make assess the multiple facets of complex environmental and health issues.

Chapter Seven: Newspapers, Power, and the Representation of Local Healthcare Social Worlds

Political Power: Cultural Recognition, or Coalitional Politics?

Since the publication of Habermas's (1962), **The Structural Transformation of the Public Sphere**, his public sphere model has been developed and updated by a variety of scholars to take into account a number of different aspects including the changing nature of the media landscape (Örnebring & Jönsson, 2004). Both Thompson (1995) and Dahlgren (1995) have argued that the mass media are becoming a central public arena through which the public can access societal dialogues. Dahlgren (1995) suggests that the media play an important part in providing this access expanding the traditional realm of public conversation into a mediated public sphere. The expansion can articulate the categories and identities available in political discourse and promote forms of pluralism essential for a working public sphere. It does this often times not through coverage of national and global politics, but by the ways that media outlets "filter and frame everyday realities through their singular and multiple representations, producing touchstones, references, for the conduct of everyday life, for the production and maintenance of common sense. And it is here, in what passes for common sense, that we have to ground the study of the media" (Silverstone 1999, p. 6, quoted in Chouliaraki, 2005). As one of the three important storytelling network infrastructures operating in the Harlan County, the local newspaper carried stories about happenings in the county and I sampled stories from a seven year period starting in 2003 until March of 2010.

Thompson (1995) discussed how the forms of societal organization where dialogue and face-to-face communication are no longer viable instruments for day-to-day democracy, having been dramatically altered through expanding electronic forms of communication (Örnebring & Jönsson, 2004). Historically, for Habermas (1962) the central struggle in the bourgeois public sphere was the struggle of one particular class to find a new place in society, while Thompson (1995) has claimed the central struggle in the mediated public sphere has become the struggle for visibility. For some authors, like Bourdieu (1997), it is not simply an issue of the competition for visibility that is affected by the mediatization of political discourse, but that the logic and contents of the political field has been displaced by market forces. Habermas (1962) himself has argued that

mediatized communication has been weakened by the interests of large-scale organizations that come to dominate the public sphere. Both Bourdieu and Habermas are concerned with the continuing viability of political deliberation in contemporary marketized mass communications (Chouliaraki, 2005).

As Örnebring & Jönsson (2004) summarize, the struggle for visibility indicates that there might not be just one mediated public sphere, but instead a media landscape that can be described as consisting of a mainstream media and a number of alternative spheres. The historic bourgeois public sphere was for Habermas the locus of *political power* in bourgeois society, while his critics, like Nancy Fraser (1992) have suggested that the modern, mediated public sphere has become an arbiter of *cultural recognition* under late capitalism. Fraser suggested that the politics of redistribution is bound up with notions of equality and is focused substantively on economic issues while, in contrast, the politics of recognition is bound up with notions of difference and is focused substantively on cultural issues. Although Fraser states that both redistribution and recognition are needed, she further argued that there has been a shift from the politics of redistribution to the politics of recognition. This is a kind of double shift that involves movement from socio-economic politics to cultural politics and from the goal of equality to that of recognition, displacing socio-economic redistribution as the remedy for injustice and the goal of political struggle. In effect, Habermas, Fraser and others who have taken up the debate around changes in the public sphere (Fraser, 1990; 1995) can be understood to be taking sides in a philosophical dilemma that anticipates the slippage in meaning between universalism and particularism that has occurred as modern politics as political philosophy has struggled to theorize the concrete reality of politics in an increasingly globalized world (Walby, 2001).

Walby (2001) explores the slippage between universal and particular representations by discussing how claims in mundane political struggles are typically neither universalist and re-distributive nor particular and concerned with of recognition (Lash & Featherstone, 2001). She argues that Fraser's claim that there has been a shift from the politics of redistribution to the politics of recognition is overstated. As such, political claims are made with reference to some middle ground between universal and particular, having to do with *reference groups*. By grounding her theory in reference groups as a

source of claims making, Walby shifts the basis of everyday politics away from party politics and national or state policy-making to the level of networks and coalitions, to the *social worlds* that for one reason or another embedded in the nature of the foci of social practices organizing the social world. She uses reference group theory to understand “why social groups choose some standards rather than others as constitutive of their interests and as focus of their aspirations” (Walby, 2001). Her shift of emphasis is part of a broader project to connect local politics and political struggles with globalization, with the increasing impact of neoliberal economic policy on the world stage. Lash and Featherstone (2001) suggest that Walby is imploring us not to make a fetish of “community” since politically engaged social groupings are closer to “coalitions” than coherent communities and, as such, may be calibrated to different scales of social influence, as well as being made up of varied and cross-cutting political affiliations.

For Walby (2001), the debate posed between Jurgen Habermas and Nancy Fraser frame a kind of “alterity between liberalism and communitarianism” that can be seen as a creative tension in political thought. Habermas and Fraser are searching, via sociological analysis, for a route through the philosophical dilemma of either/or posed by historic debates about universalism and particularism. Within this tradition, the concept of *community* is a poor and overly narrow operationalization of the *social* which is unable to articulate sufficiently the complexities of cross-cutting differences. Sociologists offer a wider range of concepts of social divisions, creating ideas about social structure that accept that human groupings cross-cut in complex ways. Utilization of networks and coalitions, and the overt abandonment of the assumption that political projects are to be based on culturally cohesive communities means we need to abandon any notion that “ethos and polis do or should map onto each other” (Lash & Featherstone, 2001). For Lash and Featherstone, the purity demanded by such a project is unachievable in the modern world. In the context of this project, there is a concern for the ways discourses like that of “community” get deployed in media to do ideological work, giving the impression of a coherent cultural community where none exists.

Chouliaraki (2005) argues that public debate in the media involves establishing a meaning horizon which delimits what is to be said and known, and which authorizes as true certain meanings and knowledges at the expense of others. This amounts to a politics

of truth at play in every mediated debate and which is central in the constitution of the debate as a public sphere. For Chouliaraki, there is a tight link between the politics of truth and the democratic potential of mediated debate. It is important here to interject that the meaning horizon is tied in many ways to the kinds of identity themes we began to explore in the previous chapter and the boundaries that help to establish, maintain, and assure support for the social dominance of particular social groups. This process potentially distances marginal groups, possibly activating the various sensitive issues that “everybody knows” are impolite, unfair, or otherwise destabilizing to bring up in public conversation. If the politics of truth authorizes the meaning horizon in which debate topics are construed, then it is by assessing the contours of this horizon -- what it includes and what it excludes as possible knowledge -- that we also assess the capacity of public spheres to deliberate without becoming entangled in destructive attacks related to sensitive issues. Another example of what I am discussing here that runs parallel to the discourses of “community” mentioned above would be ask questions about how identities like “survivor” are deployed in relation cancer prevention to describe how cancer patients are traumatized by the diagnosis and treatment for cancer, even while there appears to be no equivalent language to describe how those traumatized by mountaintop removal practices - dangerous blasting that hurtles large stones, dust and mud slides towards nearby homes; speeding coal trucks that fly by family homes overloaded with coal; water supplies and wells tainted with mud, acid, heavy metals and other pollutants, to name but a few.

Condit (1994) proposes that hegemony in mass-mediated societies does not operate on the basis of a dominant ideology, imposed by a small capitalist elite, but rather operates through a “concordance” among an “interlocking set of minimally and moderately well to do groups amalgamated with capitalists” (p. 208) to dominate more marginal groups. Under neoliberalism, corporatist modes of ownership have allowed mutual funds, banks, and other financial institutions to gamble with tax revenues, pension funds, 401K plans and other compulsory savings plans available to workers and to disperse their savings across the globe, reshaping the nature of ownership and, at the same time, shifting traditional economic interests that once underlay notions of class interests (Graham, 2006).

An example of this hegemonic process arose while I was doing my fieldwork in eastern Kentucky during the healthcare debates in 2009. Although there was a vocal minority across the country and the Congress that advocated a “public option” to be considered as part of the debate about national healthcare, that minority was quickly pushed out of the negotiations, limiting debate to plans that modified existing private insurance options or pursued market solutions to healthcare access issues (Brett, 2009; Cutler, 2010; Murray & Frenck, 2010). The non-partisan media watchdog group, MediaMatters.org, found that national media helped to skew the healthcare debate away from discussion of the public option and potentially ensured that the legislation that Congress and the Obama administration worked out would fall short of what the administration and the public were asking for, and what many progressives said was necessary (Foser, 2009; Holden, 2009; Parker, 2009). Claims made against the mainstream early detection and screening advocacy culture of action also fit this description of hegemony, particularly when those claims emphasized collusion with corporate interests concerning lack of discussion of environmental causes of cancer in mainstream promotional activities by large national charities like the Susan G. Komen Foundation and the American Cancer Society, or suspicion is expressed about the corporate origins of Breast Cancer Awareness month as a promotional ploy of the largest producer of cancer prevention medications in the U. S.

The capacity of any debate to subject its topic to rational critique by opening up to scrutiny the interested basis of *all* relevant knowledge, irrespectively of its status or power, is at the heart of what Chouliaraki (2005), as well as Walby (2001), are talking about. Walby (2001) suggests a *modest view* of democracy that is not intent on the “grand politics” of the state, or the party, but nonetheless is equally tied to institutions and to power. It presupposes a “local” view of democracy as a practice which activates minor, possibly invisible, relations of power in order to act upon individual conduct and increase its “good order”. This is a view of democracy which Rose refers to as *government* (1999, p. 6) and which Stuart Hall relates to media as *government by culture* (1997, p. 227-8). Mediatized debate, from this perspective, is understood as a device of government, a mode of ruling through *showing how* we should think and act under certain norms of civility. The *government* perspective referred to by Rose helps us approach the media

debate as a local game of power which involves the mediation of meaning resources. The key issue here is that the mediatized debate suggests which meanings are relevant for public dialogue, while also enacting certain practices of communication as the most appropriate for civic behaviour, in effect, establishing the conditions of possibility for what can be said (Foucault, 1973; Chouliaraki & Fairclough, 1999). The focus on the politics of truth captures just that aspect of government where competing discourses struggle for hegemony – for authorizing their version of truth as “the” true discourse in the debate (Chouliaraki, 2005).

Many local news stories in the HDE story set tend to perpetuate a consumer-based mentality by reducing community health and environmental issues to matters of (bio)technocratic expertise and consumer choice, with civic participation in the naturalized processes of economic development characterized at best as ineffectual, and often as an interference to the creation of jobs and community economic well-being. Importation of mainstream promotional forms *refeudalizes* (Habermas, 1962) the public sphere and implants a de-differentiating, “aestheticizing” impulse (Harvey, 1990; Chouliaraki, 2000; Fairclough, 2003) into local health-related discourses. By an “aestheticizing” impulse, these authors are referring to an impulse to distance human suffering and pain from the text while idealizing and mythologizing the power of biomedical technology. The writing style of the stories attempts to “preserve the aura of objectivity and impartiality”, while taking a pro-biotechnical stance (Chouliaraki, 2000). Complimentary themes of community participation and personal responsibility are found in homologous organizations in the region like Personal Responsibility in a Desirable Environment (PRIDE), which focuses on the environmental cleanup of solid waste and other environmental problems and Operation Unite (see chapter three), which is focused on preventing addiction. The presence of PRIDE, a non-profit organization created by congressman Hal Rogers and General James Bickford, former Secretary of the Kentucky Natural Resources and Environmental Protection Cabinet, deflects attention from environmental issues related to coal production by focusing on illegal dumping of trash and other regional issues that can be characterized as individual causes of local pollution. Similarly, Operation Unite acts to build and maintain community coalitions in opposition to drug abuse, encouraging community members to report drug users to local

law enforcement and to cooperate in the apprehension and prosecution of those who grow marijuana locally or sell prescription medications. In each of these cases, community participation is encouraged only to the extent it supports mainstream promotional campaigns for environmental cleanup or drug enforcement (or for cancer prevention, in the case of cancer prevention coalitions), and typically as a means to access grant funding or as a means for fund-raising for community organizations and projects.

Each of these entities (local cancer preventions coalitions, PRIDE, and Operation Unite) strive to create an image of “community” through media visibility, evoking a political imaginary dependent on the narrow participation of “citizen-consumers” (King, 2006), who are primarily enjoined to “participate” through buying services (or, at least, by presenting one’s eligibility to access subsidized services) and donating money to the philanthropies or causes endorsed and legitimized by the mainstream in each of the organizations. The citizen-consumer is a meta-identity existent in the ethos of mainstream neoliberal participatory governance such as the cancer prevention culture of action, which advocates self-betterment and quality of life through consumption as the normative mode of conduct (King, 2006). This meta-identity is part of a broader consumer-oriented promotional discourse, which has a colonizing effect on deliberative communication and colonizes the same deliberative democratic process, under neoliberalism, framing conflict and dissent as passions that are dangerous and destabilizing. This tends to perpetuate the notion that democratic freedoms are exercised through the purchases one makes, including the buy-in to mainstream prevention formulae.

This ethos is particularly evident in media representations in the public sphere where activism has come to be understood as naïve, ridiculous, shallow and dangerous and personal witnessing about trauma or injury are the valued political testimony (King, 2006). The proliferation in the public sphere of “survivor” discourses creates a space within which the subject position of “survivor” becomes a meaningfully visible, cultural notion (Orgad, 2009). It refers to a wide range of experiences of suffering and struggle and is embedded within the contemporary cultural environment in which trauma has become an “envied wound”, a culture that invests traumatic experience with moral value and authority (Mowitt, 2000).

My argument in this chapter combines two analyses. First, examining the thematic

structure of the newspaper stories, I explore how, over the seven-year period during which I gathered stories, historical definitions of issue elements are constructed so that they preserve boundaries between healthcare and cancer-related stories and environmental issues. The story lines that aggregate in various story clusters draw on repeated use of certain categories and classifications to sort actors by network participation aligned with various inter-organizational cliques. The historically specific conditions represented by the news stories do the ideological work of naturalizing conditions and making them appear inevitable, while also positioning certain organizational actors as authorities even as they diminish or exclude the other actors.

Second, by focusing on the dialogical aspects of the stories which involve the direct reporting informant's speech, I analyze how choices to report the news in terms of whose discourse is directly quoted and whose is paraphrased, summarized, or indirectly reported create networks of relations. These networks have the effect of mystifying power relations by collapsing social identities, relationships and distances, making local elite voices appear to be more "like us". This has the overall effect of rearticulating the relationship between the public and private sphere in such a way as to make political issues appear to be individual issues rather than collective ones. I bring these two analyses together by illustrating how social structures emergent from the stories position local and state government as central actors in the community, supported by the local health department and hospital, ignoring or minimizing the environmental impacts of local coal production and restricting voices concerned with cancer prevention to a focus of lifestyle and individual responsibility.

Who is Visible and Why? Local Cultures of Action and the Colonization of the Lifeworld through Newspaper Stories

Following Törrönen (2001), the subject position in texts is a construction which, on the one hand, evolves in a specific relation to the audience and to the existing subject positions in particular contexts of interaction. On the other hand, it obtains its meaning by being attached situationally to categories and story lines (See **Table 1: Method for Interpreting Story Positioning from Törrönen, 2001a** (p. 320-3220) (Appendix A). Accordingly, subject positions evolve in communication as a co-effect of three elements: categories, story lines and positionings (viewpoints).

Table 1: Method for Interpreting Story Positioning from Törrönen, 2001 (p. 320-322)

Aspects of subject positions	making categorizations and classifications	historical paths as story lines	structures of interaction and viewpoint in communication
spatial aspect of the construction of subject position	(1) What kinds of social motives the speakers consider rational, self-controlled and autonomic as distinct from those that are irrational, passionate and dependent?	how the speakers value, with pragmatic modalities, the action under consideration	The positions and postures into which texts position speakers and audiences always evolve in intertextual relation to other possible positions, voices and viewpoints, on the one hand, and in relation to the categories and story lines, on the other hand.
temporal aspect of the construction of subject position	(2) What kinds of social relationships are open, trusting and honorable as distinct from those that are secret, suspicious and self-interested?	<i>obligation</i> - refers to deontic qualifiers, to expressions like compulsion, prohibition, command, permission or optionality <i>want (will)</i> - expressions indicating desire, passion, lust, willingness or unwillingness	expresses whose identity (or part of the identity) the use of a subject position rhetorically strengthens and whose identity (or part of the identity), correspondingly, the use of a subject position weakens or shakes
positional aspect of the construction of subject position	(3) What kinds of social institutions are considered rule regulated, contractual and equal as distinct from those that are arbitrary, class prejudiced and hierarchic?	<i>ability</i> - expresses the situational resources (physical, psychic, social, technical) to act <i>competence</i> - expresses know-how that are acquired and internalized	group identities, institutional identities, national identities and global identities are partly stabilized and transformed by discursive structures

Törrönen's (2001) first conceptual distinction, categories, points to the ways that the narrators or the speakers articulate and locate their values in texts in mirror-relation to Others by making categorizations and classifications. Törrönen terms this the spatial aspect of the construction of subject position because classifications establish a boundary line between inside and outside, and, as Fairclough (2003) might suggest, creates a territorialized understanding of civil life based on the networking of social practices into orders of discourse. Territorialization provides a spatial context within which interactants may express (1) what kinds of social motives speakers consider rational, self-controlled and autonomic as opposed to social motives considered irrational, passionate and

dependent, (2) what kinds of social relationships are understood as open, trusting and honorable instead of secret, suspicious and self-interested, and (3) what kinds of social institutions are considered rule-regulated, contractual and equal as distinct from arbitrary, class prejudiced, and hierarchic. In different situations and contexts of interaction these contrasts become attached to different contents and their articulation into a segregation between Us and Them is not always based on strong a binary or oppositional framework but may also be delineated, by only weakly drawing weakly defended boundaries between Us and Them, flexibly and convertibly instead of rigidly and exclusively.

Categorizations between Us and Them are embedded in historical paths that can be understood as particular story lines (Davies and Harré, 1990, p. 47). Törrönen (2001a) calls story lines the temporal aspect of the construction of subject positions and it can be traced through how subject positions are attached to temporal adjuncts examining how the speakers value, with pragmatic modalities, the action. This temporal approach resembles how Fairclough (2003) uses modality to examine the relationship between social identity and personality in texts at the individual level and between culture and the standardized character types of shared cultural myths and ideologies at the collective level. In Fairclough's approach, modality (i. e., linguistic elements like modal verbs, modal adverbs, and participial adjectives) is related to the construction of identities in texts through the ways modality represents speaker's commitments to the statements they make. My interest here is with the construction of standardized story character types and their relationships to organizational actors in the Harlan County stories. Both King (2006), in her discussion of the construction of "consumer-citizens", and Erhrenrich (2009), in discussing the place of cancer recovery "marketplaces" associated with cancer charity websites, point to the associations between mainstream cancer prevention, pink ribbon culture, and the construction of consumer-based identities that are structured wholly out of positive, self-affirming images, with little tolerance for the critique of biotechnical practices of cancer medicine, nor the consumption-oriented health promotion. These discourses also appear to be silent concerning the possibility that environmental exposures may be affecting cancer rates in the US. In this atmosphere, open discussion of sorrow, disgust, disappointment or other negative reactions to the biomedical cancer regime can lead to offending complainants being ostracized. Questions

about environmental dangers are seen to be taboo altogether.

In addition, categories and story lines are articulated into particular structures of interaction and viewpoint in communication. Törrönen (2001a) calls this the positional aspect in the construction of subject positions. The positions and postures into which texts position speakers and audiences always evolve in intertextual relation to other possible positions, voices and viewpoints, on the one hand, and in relation to categories and story lines, on the other hand. The positional aspect of subject positions is important because it expresses whose identity (or part of identity) the use of a subject position rhetorically strengthens and whose identity (or part), correspondingly, is weakened. Communication does not solely involve a lone actor whose boundaries of temporality and posture of identity are also stabilized, transformed or performed. Group identities, institutional identities, national identities and global identities are also partly stabilized and transformed by discursive structures. Törrönen (2001a) summarizes the impact of subject positioning in as a kind of “discursivization”:

This kind of discursivization constructs for the endogenous and marginal people living within a state territory an identity that they do not easily identify as their own. Spatially the boundaries of their identity become defined as subordinated to national hegemonic culture, temporally their history of origin becomes overwritten by the dominant history, and positionally their marginal ethnicities become positioned in a role of anti-subject or, at best, that of helpers who enrich the national culture. Therefore, critical political studies have aimed at shaking both the stabilized national identity boundaries and their legitimation in homogeneous and linear story lines, not solely by deconstructing and reconstructing the scientific texts that maintain modernistic illusions but also by critically reading various media texts. Because discourses tell who we are and what our relation to reality is, the researchers engaged in critical political studies see that their primary task is to undo subordinating subject positions and to promote their rearticulation into alternative categories, story lines and positionings (Törrönen, 2001).

The issue of visibility, then, has implication for the Appalachian communities I examined both in terms of whether the claims that coalitions are “grassroots” actually break through the insularly commodifying forces at work in the continuing processes of privatization in medicine, as well as whether or not mainstream cancer prevention groups actually speak for a “community”, or some inter-organizational clique of interests affected by the distribution of cancer prevention services. As mentioned in earlier

chapters, local cancer prevention activity are manifest in one of two cultures of action (Klawiter, 2008) in the area from which I drew my sample of newspaper stories. The first culture of action is the culture of early detection and screening activism, of which the county cancer prevention coalitions take part. The Harlan County Health Department (HCHD), Harlan Appalachian Regional Hospital (HARH), and the American Cancer Society (ACS) the primary organizational entities represented in these stories, with ACS by far dominating the cancer prevention discourse. (Only one story actually mentions the local cancer prevention coalition sponsored by HCHD.)

The second culture of action represented in the newspaper stories was the cancer prevention and environmental activism culture. This culture of action has been evolving mainly in response to the environmental destruction of mountaintop removal mining. In analyzing themes underlying the story set, the word “group” repeatedly came up as an index for environmental groups and social movement organizations. The most publically recognized group of this type operating in eastern Kentucky is Kentuckians for the Commonwealth (KFTC), but other groups also appear to be indexed by the term. A number of researchers have published results that demonstrate clearly the profound consequences of mining on the health of communities where coal mining occurs have been incorporating the findings into their actions against MTR. Since a great deal of MTR has occurred in proximity to the headwaters of important watersheds in eastern Kentucky, the most prominent actions have been to question mining practices that pollute water supplies and destroy streams and their ecosystems (Hitt & Hendryx, 2010).

Methods and Data

As before, I continue to work a sample of the newspaper articles drawn from the Harlan Daily Enterprise newspaper described in the previous chapter. The paper was searched and stories found in electronic form from March 2003 until February 2010. My searches utilized the keywords “cancer” and “cancer prevention” for cancer prevention stories and the keywords “environment”, “water quality”, “sewer”, and “roads” for environmental stories as well organizational searches for “Harlan County Health Department”, “Harlan Appalachian Regional Hospital”, “American Cancer Society”, “Kentuckians for the Commonwealth” and “fiscal court”. HCHD, HARH, and ACS constituted the primary organizations represented directly in cancer prevention stories. To

assure a thorough examination of stories, I also searched the database for stories about each of the three organizations. This procedure allowed me to see overlaps for HARH with the coal heritage of Harlan County and to see examples of the multiple pressures put on the HCHD to address the extensive range of issues they are obligated to address.

Based on qualitative research methods by Törrönen (2001a) and Bogren (2010), I structured my analysis of stories in the following way: I (1) wrote down a common sense-based summary of what the texts are about; (2) identified themes in the data; (3) mapped important concepts and social categories within each theme; (4) identified chains of association that define the meaning of central concepts and categories; and (5) applied distancing techniques to clarify meanings. Identified subject positions in the stories involved the three elements discussed above by Törrönen (2001): categories, story lines and positionings. Thematic development was expanded through the use of CRA (Corman, Kuhn, McPhee, & Dooley, 2002), facilitated by the Crawdad software, with categories and classifications being organized from review of CRA word networks and larger clusters of words and or stories, examining keywords-in-context based on important terms elicited through the Crawdad software, and by examining other linguistic resources in the stories relevant to the appraisal system in language as discussed by White (2000), Fairclough (2003), and Martin and Rose (2003).

To trace the value-orientations of subject positions, it is necessary to analyze use of pragmatic modalities in communication. This method differs from the norm theoretical tradition of sociology which study orientations to social action in terms of prohibitions and orders that are external to action itself (Sulkunen and Törrönen, 1997, pp. 45–46). In the approach used here, action is determined through ongoing negotiations of social actors also by modal qualifiers in discourse itself as opposed to rule-based obligations imposed by external authorities.

The methods of discursive analysis discussed by Sulkunen and Törrönen include the use of modal operators or modal verbs to express a speaker or author's commitment to claims made in texts in relation to subject positions (Törrönen, 2001a). Subject positions are constituted in part through at least four groups of pragmatic modalities—*obligation*, *want (will)*, *ability*, and *competence* (Sulkunen and Törrönen, 1997). *Obligation* refers to deontic qualifiers, to expressions like compulsion, prohibition, command, permission or

optionality. The modal group of *wanting* embraces expressions indicating desire, passion, lust, willingness or unwillingness. *Ability* expresses the situational resources (physical, psychic, social, technical) to act and the modal group of *competence* expresses know-how that is acquired and internalized (Törrönen, 2001a, p. 46). Here, communication, rather than command rules.

Contrary to traditional sociology that focuses on norms, orders, and prohibitions, the norms which emerge in discourse are neither slowly changing social facts, nor deep are they deep structures of culture. Instead they are relational determinants that each text and turn-taking exchange undoes and reconstructs through the mediation of linguistic modal qualifiers. This analysis of the use of pragmatic modalities discloses the orientations of subject positions to action. By means of pragmatic modalities the text/speech “names” objects under desire, will, or obligation, thereby demonstrating the abilities (resources) and the know-how (competence) that the culturally skillful performance of the action implies. Often the attachment of subject positions to hoped-for value-orientations is strengthened by the story of the anti-subject, which exemplifies, as a warning story, what could happen if we do not adhere to the proper values in our action.

To elaborate my discussion of subject positions, networks I initially extracted from the newspaper stories according to an actor-by-story matrix, organization-by-story matrix, and actor-by-organization matrix. Matrices and the qualitative categories they were linked with direct quotes from actors represented in the stories. This grounds the categories and social networks in direct reports and has a potential for establishing a dialogical, intertextual linkage among categories (Fairclough, 2003). In some cases, particularly in situations where previously identified cancer survivors were discovered in newspaper obituaries, actors and organizations, I coded based on indirect reports of who participated in funerals or funeral arrangements. **Table 1: Method for Interpreting Story Positioning from Törrönen, 2001a** displayed above summarizes this method for studying subject positions based on discursive resources. In addition, two clusters of stories from the previous chapter will be further analyzed (see **Table 2: Breast Cancer Awareness and Mining Accident Story Clusters**).

Cancer Awareness Themes

Social Motivations Considered Rational, Self-controlled and Autonomic

Table 2: Breast Cancer Awareness and Mining Accident Story Clusters

Story	Headline
10/15/2003	Harlan woman discovered cancer can strike people of all ages
10/17/2003	Lynch woman stresses positive attitude to cancer patients
10/14/2003a	Events planned to fight cancer
6/25/2007	Hendrix drives home importance of early detection
11/6/2009	County native honored for helping cancer patients
10/16/2003	Life 'a gift' for cancer survivor
6/20/2009	Being a cancer survivor is an honor
10/14/2003b	Hensley finds satisfaction in job helping others
10/22/2009	Early detection crucial to fight breast cancer
5/17/2003	JACHS senior wins big game against cancer
11/1/2006	Being a cancer survivor is an honor
Story	Headline
5/22/2006	Five miners killed in explosion
7/15/2006	Widows ask for tougher legislation
4/22/2006	Miner killed in accident - McKnight pinned between machinery
1/1/2007	Coal officials are satisfied with new laws
11/12/2007	Father, son found dead at old mine
12/30/2006	IS NEW LEGISLATION ENOUGH?
6/28/2006	Darby employees to testify today Families' representatives not allowed to attend interviews
7/27/2007	Judge: 'Plot thickens' in Darby case
10/11/2007	Teamwork stressed during a mock coal mine disaster
2/28/2006	Deadly mining practice gets no attention

Eleven stories were included in the Breast Cancer Awareness cluster of stories and ten stories in the Mining Accident cluster. The core stories from in the Breast Cancer Awareness cluster were first published in October 2003 as part of a series by the Harlan Daily Enterprise related to Breast Cancer Awareness Month. The stories are cut from the mainstream promotional cloth, offering a simplified vision of moral conduct based on being a good “consumer-citizen” (King, 2008). Participation in the cycle of local promotions and for campaigns defines the broad outline of this behavior, and includes paying tribute both to the miracles of modern biotechnical medicine and past support from local volunteers for the American Cancer Society. Personal stories of cancer survival serve as testimonials for the value of biotechno-medical intervention and ACS programs, justifying eventual sales pitch in the stories for contributions to sustain an envisioned future where cancer is eliminated. The stories also act suggestively to

recommend that other women follow the same course as that of the survivors, submitting to screenings regularly, hailing the female reader to identify herself as a “risky subject” (Klawiter, 2008). In this way the identities of local cancer patients are appropriated in service of the goals of the culture of action and used to define the nature of cancer risks in the community as well as to define involvement in early detection and cancer screening activities as a rational response to risk.

Seven of the eleven stories incorporate survivor stories, with six of the survivors being female and one male. All the female survivors developed breast cancer (with one of the six also experiencing bouts with colon cancer and lung cancer). Two of the seven survivors were under the age of thirty, mirroring McKay and Bonner’s (2001) observation that the youthfulness of survivors in mainstream publications is often overstated (in the entire set of stories there are at least ten survivors under the age of forty, the youngest being only six years old), often being deployed to intensify the reader’s interest and identification with the story. Females constitute the primary focus of cancer prevention stories.

Only five males are identified in the entire story set as experiencing cancer, one of them a high school student who was the local winner of an ACS scholarship and whose story is included in the cancer awareness story cluster. Of the other four males identified, only one has his story told at length; that of an exceptional young male medical student from Harlan County who returns to practice medicine in the county after surviving both cancer and medical school.

Race was strangely absent from health story content. Many stories did not have pictures of persons involved with the stories, so obvious racial markers were not available in the stories, but there appeared to be no mention of race or ethnic/racial barriers to health care access in any of the stories. I was able to identify one young female survivor from a story (not part of the breast cancer awareness cluster) as black by doing an internet search on survivor names and discovering a picture of the young woman on Facebook. Another story in the set described how an HCHD sent a representative to a local school board meeting along with a parent group to protest excessive expulsions of black students from the Harlan High School when discipline problems were involved. Race was otherwise not apparent in the representations of the health stories (or the environmental

stories, for that matter). Though only 2.2% of the population of Harlan County is black according to the 2010 US Census (Census QuickFacts, 2011), that still constitutes approximately 644 persons. There appears to no mention of access difficulties for health care in this community in Harlan County.

Discussions of whether class and income disparity that might be affecting health care provision in Harlan County are also absent. None of the ACS stories mention eligibility requirements for KWCSF and in no story is the cancer rate in Harlan County explicitly connected to issues of poverty and income disparity. No stories discuss the changing nature of work in the county, nor do they discuss the declining provision of health insurance by employers. Only two stories bring financial issues up explicitly in relation to healthcare access and neither of them is in the breast cancer awareness cluster. One story describes HARH's "Cover the Uninsured" week promotion in which the hospital sought to inform the local community about the importance of state and federal subsidy programs to sustaining the hospital's not-for-profit status. The other described how a local woman became involved with HCHD when she was able to access treatment for her breast cancer thanks to KWCSF. This story was related to the discussion in the previous chapter about the KWCSF and involved the same two health department providers mentioned in "Hensley finds satisfaction in job helping others" from October 2003.

One can argue that the stories about cancer and cancer prevention, presuppose many readers, because they can find links to family members or friends who have had cancer, are hailed by the stories and thus drawn into the imagined community of consumer-citizens. Only six of the health stories overall, and none of the cancer awareness cluster stories, discuss environmental issues. Two stories focus on mercury spills in two local schools, while two discuss the relationship between HCHD's environmental services and homeland security. The other two stories discuss radon detection in homes and grease trap issues at local restaurants, respectively. Participating in promotions, giving donations, and walking in "Walk for" activities that are oriented to raising money for cancer research are ritual gestures that demonstrate one's "awareness" of cancer and its detrimental effects, but there is little effort to extend this awareness to a libratory consciousness that would confront sensitive issues in the community like class- or race-based differences that create obstacles to medical access in the first place. The disabling

or disfiguring effects of cancer treatments are sidestepped by discussing ACS programs offering wigs and other feminine products to those receiving treatment without actually going into the reasons one might need these products.

Concerns about water quality and other toxic exposures do not appear in the healthcare stories, but are mentioned in several environmental stories about sewer system upgrades in the county. The local population is assumed to be both white and working at a job that provides health insurance. The rational healthcare actor in the HDE stories clearly is a “risky subject” enjoined to exercise autonomy through lifestyle changes to improve health, purchase, and participate in cancer prevention rituals at both the personal and community levels, and they draw no connections between local mining activity and rates of cancer in the region.

Social Relationships Considered Open, Trusting and Honorable

In **Table 3: Dialectics of Discourse: Cancer Screening as Social Practice** from the previous chapter, five relationships were listed in relation to the KWCSF: provider – recipient; recipient – recipient family; provider – recipient family; volunteer – potential adherent; provider – payer source. Two other relationships can now be added here, that of recipient – payer source and organizational coordinator - volunteer. Provider – recipient is a generalization of the historically prototypical relationship between doctor and patient generalization “provider” to account for the fact that KWCSF does not make screening the exclusive domain of physicians, and allows for a small number of other qualified providers to also deliver cancer screening services. It also takes into account that medical services are being delivered by teams of service providers in modern medical organization. Many of these are traditional medical providers, but teams may include professionals from various allied health services. Recipient – payer source, provider – payer source, volunteer – potential adherent, and organizational coordinator – volunteer all involve other vectors from which parties become involved in prevention activities. Breaking down relationships this way complicates medical rhetoric that tends to oversimplify representations of medical relationships by reducing them to the doctor - patient dyad. In the biomedical regime currently operating in the US, this reductionism can be seen as ideological, enshrining a single dyadic relationship when it is likely that many interactions within the medical system are at least triadic (such as provider –

Table 3: Dialectics of Discourse: Cancer Screening as Social Practice

Elements articulated in social practices	Action and Interaction	Social Relations	Persons	The Material World	Discourses
Cancer screening as social practice	Comprehensive health history	Provider-recipient	Licensed physician, nurse practitioner, or physician assistant	Cancer screening and surveillance technologies	Discourse of the Early Detection and Cancer Screening Activism COA
	Physical examination	Recipient - family	RN with DPH approved Breast and Cervical Cancer training course	Medical samples for lab work	Administrative discourses which shape provider preferences, and recipient eligibility and confidentiality
	Referral	Provider – recipient family	Allied health support professionals	Educational materials and promotional incentives	Discourses defining payment sources
	Documentation of return clinic appointments	Volunteer – potential adherent	Reception	Out of pocket fees and insurance payments	Interview and exam formats; notes and transformations into billing documentation
	Follow-up of abnormal results	Provider – payer source	Screening recipient(s)	Medicaid or Medicare payments	Referral and follow-up scripts

recipient – payer source) and may include larger configurations of actors.

The survivor-focused stories tended to “display the emotions of survivors for public consumption and unfailingly mediate the survivors' discourse through expert analysis and interpretation” (Alcoff & Gray-Rosedale, 1993). The survivor interview discourse in the stories is typically prefaced with a lead-up that explains how a survivor was caught off guard by the diagnosis of cancer, thus having the routine of their daily lives thrown into chaos. The survivor explains the reactions they experienced as they were drawn into the cancer treatment process. Survivor quotations are interjected by the story author to supplement the broader narrative of the news story. The broader intent of the story is to answer questions about the impact of treatment on personal appearance, to respond to family concerns about the diagnosis, and to describe social supports available for the

newly diagnosed and their families. Use of direct quotes by the survivor are part of the generic convention that utilizes survivor insight to clarify responses to the diagnosis, but also to answer questions the story author assumes audience has questions about cancer treatment. In some cases the story author presents statistical evidence, but more often direct responses by local experts are inserted as a source of information that at once answers the assumed question, defines what services are needed to address the medical issue, and explains where a service is available in the community. This “information giving” is matched to the eventual sales pitch at the end of the news story for a program, typically an ACS program that offers the services discussed in the information giving sections. Hence what starts off as a touching moment of personal disclosure by a survivor becomes a hierarchical relationship as an expert enters the conversation and makes meta-commentary that projects a particular vision of the future into the story-telling.

The generic format of the news story, with its nucleus-satellite structure, allows each story to unfold in relation to its overall promotional goals as well as news goals, organizing the relationships between providers, recipients, recipient families, and volunteers by downplaying the ability of families to understand what their family member is going through and validating the supports offered by the volunteer and their supporting organization. This has the effect of shifting the “confessional” disclosure inherent in the survivor relationship away from private relationships among family members to a confidential relationship between various proxies (doctor, doctor-substitutes like nurse-practitioner or physician assistant, or ACS volunteer).

The quality of support by families is questioned because the typical assumptions are either that the family cannot understand what the cancer patient is going through because they haven’t “been there”, or because families are fragile and must be protected from the news of the diagnosis, including the facts of the illness and its potential impact on their loved one. One element of this assumed breakdown in empathy that is repeatedly discussed is the potential concerns women have about their appearance. Rather than a frank discussion of the potential for disfigurement after mastectomy, what ensues includes references to various ACS programs that supply feminine beauty aids, wigs, prosthetics and other consumer products. Additionally, bonds between survivors and ACS volunteers are typically framed in the language of fate and are sanctified as destined

somehow. The sanctity of this relationship is eventually used to validate the importance of the ACS program as well as to stress the importance of involvement in the early detection system so that “risky subjects” might be surveilled and cancer detected if it is present. The shift here is one that constructs women in the community as “risky subjects” and positions them as in need of the services of the various organizations offering services.

Social Institutions Considered Rule Regulated, Contractual and Equal

Though the stories figure individuals as central to cancer prevention activities related to breast cancer awareness, they nonetheless mask the broader positioning of organizations as necessary for service provision while also clouding distinctions between public – private, for-profit – non-profit, and compulsory – voluntary. While a number of authors have complained that the New Public Health’s focus on lifestyle and personal responsibility shifts the locus of agency from collective forces to individual agents, I would argue that the issue is more complex and ambiguous. What appears to happen when one shifts the focus to local coalitional governance is that rhetorical deployment of political claims are in relation to various local *reference groups*, which are made up of interorganizational networks of community organizations and their intersections with local personal networks. In this way the basis of everyday politics shifts away from party politics and national or state policy-making to the level of organizational networks and coalitions. In other words, to the *social worlds* which are emergent in relation to focal activities of concern in the locale. The status of these reference groups and the claims they deem to be legitimate shape the horizon of truth that structures public debate. Organizations that are able to elicit the attention from local news media get more space in newspapers for their rhetorical claims, establishing themselves as official sources for news reporters (Gamson & Wolfsfeld, 1993). By virtue of their location in an organizational hierarchy, actors may gain status as spokespersons with local news making.

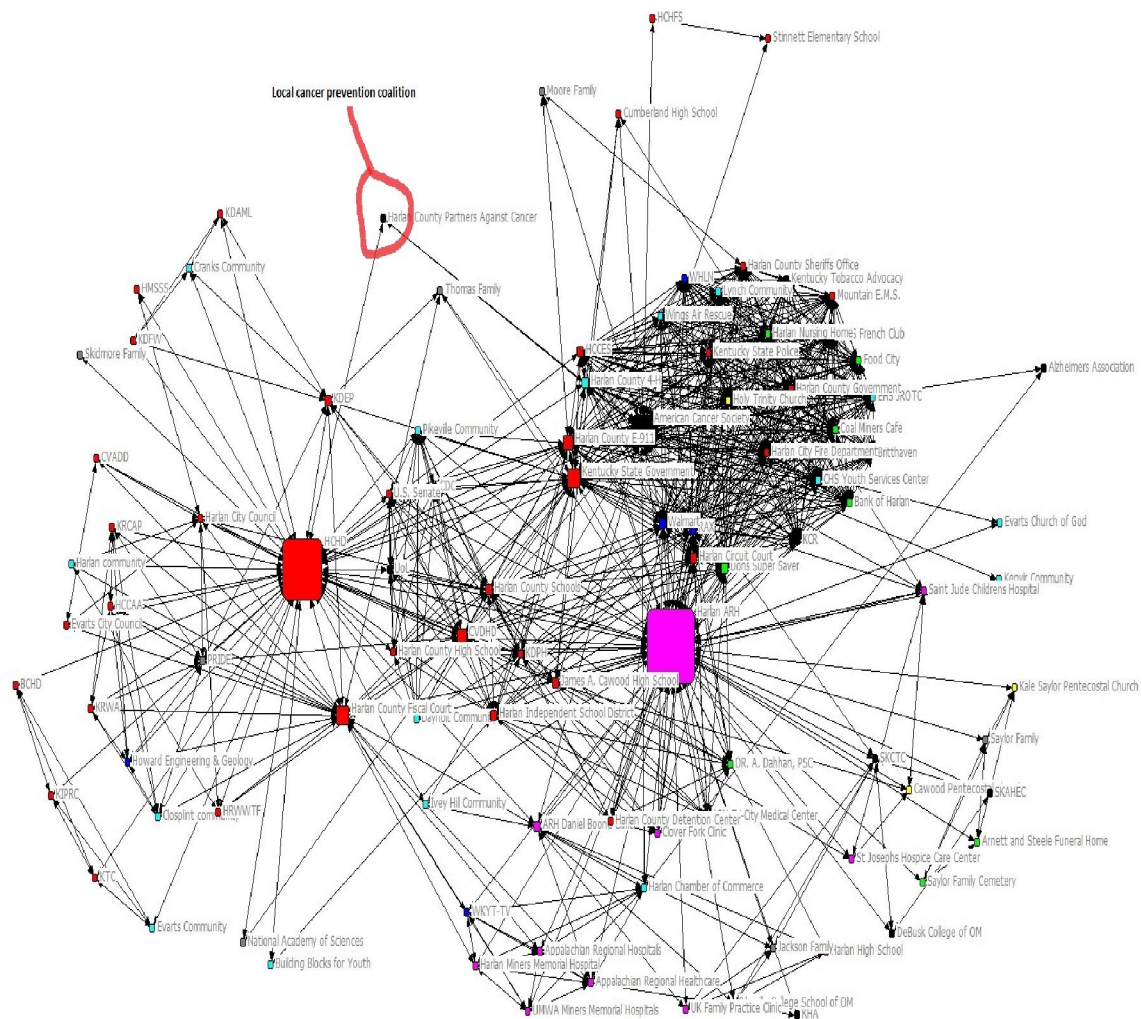
For local community members, having one’s voice elevated to a valuable opinion in news discourse is dependent on establishing one’s association with some kind of “organizational personhood”, whether that be through employment in a for-profit business or corporation, through being a member of government, through volunteer status

with a non-profit organization or chartered advocacy group, or by being a recipient of the services of one of the previously mentioned organizational entities. In large part, this is a boundary construction and maintenance process that segregates “Us” from “Them”, most typically through assigning roles within institutional activities. *Rule regulation* and *contractuality* appear to be achieved mainly through the consistency of cancer prevention messaging and by reliance of the status of service providers and volunteers on their organizational personhood. Three organizations serve as the basis of a local “concordance” about cancer prevention in local media, the American Cancer Society (ACS), Harlan Appalachian Regional Hospital (HARH) (and its affiliated clinics), and the Harlan County Health Department (HCHD) (Condit, 1994). The local cancer prevention coalition is marginalized by appearing in only one story in the set and associations with the Kentucky Cancer Program and other state level organizations never surface as part of the discussion about cancer prevention in the county. Equality appeared to be assumed across the board in the community as represented in the HDE stories and the impression of equality was maintained by simply ignoring race and class as issues affecting health care services.

Institutionally, medical care and health prevention activities, as I have said, are primarily associated with three organizations in Harlan County –ACS, HARH, and HCHD. **Figure 1: ACS, HARH, and HCHD Cliques as Ego Networks** represents their three associated cliques as ego networks, with the same color code scheme used in the previous chapter to depict the status of the various organizations in the clique. HARH is the largest node in the diagram and is positioned to the right of the center of the diagram. ACS is located just above HARH in the densest cluster of nodes in the diagram. ACS is part of a cluster of nodes that is made up of corporate organizations, local businesses, and a few local groups and government organizations. These organizations are tied into ACS mainly through participation in Relay for Life, or other ACS programs. HCHD is positioned to the left of HARH and is part of a cluster of government organizations that is concentrated on the left of the diagram. The three organizations have identity in the community, at least partially for HARH and HCHD, as being the face of cancer prevention in Harlan County.

The local community cancer prevention coalition, Harlan County Partners Against

Figure 1: ACS, HARH, and HCHD Cliques as Ego Networks (betweenness –size; status – color)



Cancer, is a marginal black node above and to the right the HCHD node (indicated by the red line to highlight it). Harlan County Partners Against Cancer appears in only one newspaper story in the seven year period from which stories are drawn, diminishing the probability that the coalition appears enough in local media to capture reader attention. ACS, on the other hand, appears in thirty-five of the ninety-one health-related stories.

Together, ACS, HARH, and HCHD constitute the basis of a local reference group that shapes local opinion about questions concerning cancer. As the primary organizational entities related to cancer prevention, it is the perspectives of these three organizations that serves as the basis of local “concordance” (Condit, 1994) about cancer prevention in local media. HCHD is embedded in the larger media representation of community

organizations as a government entity with enforcement powers affecting participation in local public works projects like the sewer and water quality projects in the county, compliance with disposal practices of grease and other organic wastes related to local restaurants, clean-up after toxic spills like the mercury spills at local schools, participation in Homeland Security preparedness, and flu vaccination, as well as being central to the local cancer early detection and screening activism culture of action and the primary gate keeper for accessing cancer-related medical services related to cancer through the KWCSF. HARH is the hospital and community clinic system providing the bulk of primary care and hospital health services in the county. It is the local site of a great deal of screening activities as well as cancer treatment. It is important to recognize that HARH claims in several HDE stories its part in the coal heritage of the county, as well as being on record in one story as supporting uninsured in the community through its “Cover the Uninsured” week promotion. ACS offers a variety of cancer-related programs, mainly as part of the treatment process for cancer, with HARH making its facilities available for many of the support groups and individual visits for those afflicted by cancer. Other organizations in this clique are marginal to the cancer prevention culture of action.

In **Figure 1: ACS, HARH, and HCHD Cliques as Ego Networks** above, the node size is used to depict betweenness centrality – the larger the node, the larger the betweenness centrality value of the node. As stated in Chapter Four, centrality is a structural attribute of nodes in a network. It is not so much an attribute of the actors themselves, but of their structural position in the network (Borgatti, 2008). It is a measure of the contribution of network position to the importance, influence, prominence of an actor in a network. Measures of centrality are an index of an actor's potential for importance, influence, or prominence based on network position alone. Betweenness centrality is the node attribute that indicates how often a node lies on the shortest path between two other nodes (Borgatti, 2008). It is an index of potential for gate keeping, brokering, controlling the flow of information or resources, and also for connecting otherwise separate parts of the network. It is used as an indicator of power and access to the diversity of what flows.

In the combined cliques of ACS, HARH, and HCHD, the two largest nodes are Harlan

ARH and HCHD. As mentioned above, HARH is the hospital and community clinic system providing the bulk of primary care and hospital health services in the county. The HARH clique contains most of the nodes from all three of the clique sets and gains its central status from being a bridge that ties many state and government level organizations and local health care organizations. The betweenness centrality values for these organizations are based not just on their part in cancer prevention activities, but by the diversity of thematic domains in which the two organizations are involved. HARH appears not just in stories about its own activities, but frequently is co-present in stories about ACS. Using a centrality based network model emphasizes the relationship of organizations in terms of their impact on the flow of meaning across the story set. HARH occupies a central position because it bridges many domains in the community, and as mentioned above, is the primary medical entity with resources to do primary medical care, prevention, and early detection, as well as surgical and chemo- or radiation therapies for cancer.

When we put the ego networks of ACS, HARH, and HCHD back into the expanded network of organizations extracted by analyzing all the stories together, Kentucky State Government now emerges as the most central organization overall. This is depicted in the diagram, **Figure 2: Betweenness Centrality of Complete HDE Story Set** (betweenness –size; status – color) below. This diagram suggests that the state government is understood as the final arbiter of regulatory authority across both domains (i.e., healthcare and environmental) by local news. Many stories use state authorities as a voice to legitimate local decision-making and confirm that local organizations are acting within state regulations.

Another way to examine how organizations are positioned in terms of their importance as story sources is to use a block model (Wasserman & Faust, 1994) to depict core and peripheral entities in the stories. The positions in a block model are defined by regularities in the patterns of relations among actors, not attributes of the actors themselves. Identifying and studying positions through block models means studying relations among actors rather than studying attributes of individual actors. Many "attributes of individuals" such as race, religion, and age can be analyzed as patterns of relations, with what might at first appear to be an attribute of an individual really being a

both story sets.

The block model represented in **Figure 3: Section of an Optimized Block Model of HDE Stories** (see the Chapter Six Appendix A), tells a similar story to the depiction of central organizations. Along with the Harlan County Fiscal Court, Kentucky State Government, the Cumberland Valley District Health Department, and Harlan County Schools, HCHD is part of the part of the core of organizations that act as important sources for the local newspaper. HARH is in the Strong Semi-periphery, while ACS is part of the Weak Semi-periphery in the community representation.

The centrality of some organizations, like Kentucky State Government, HARH and HCHD, as well as the core status of these same organizations in the block model suggests that they are positioned mainly through their repeated use across both cultures of action as preferred sources for local news. They are favored to provide answers when disruptions to daily life in Harlan County occur. Hence, these organizations and the stories they tell are important to figuring the “imagined community” that is part of the horizon of truth that validates and legitimates particular interpretations of what it means to live in the county. Their alignment with the mainstream early detection and cancer screening advocacy culture of action and failure to confront the destructive consequences of mining and support the cancer prevention and environmental activism culture of action assures that media representations will continue to frame issues in the public sphere in favor of hegemonic interests.

Story Lines, Modal Verbs, and Speaker’s Commitment to Claims Made in Texts

The Breast Cancer Awareness Cluster and the Modal Verb “Can”

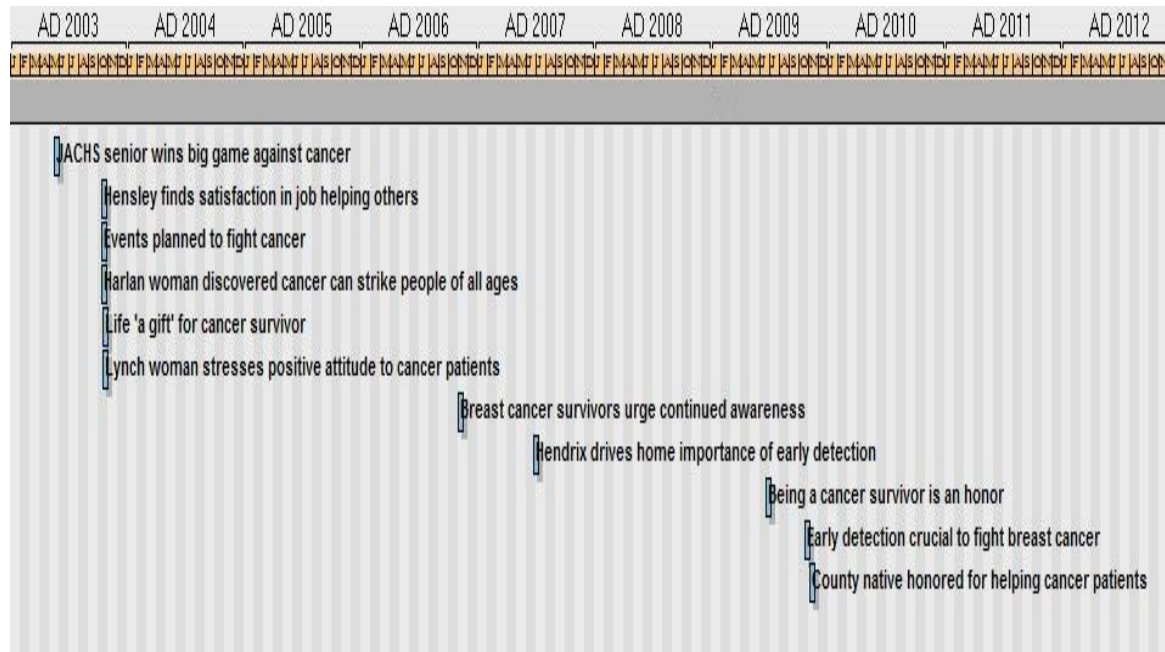
And I think that one of the big issues with pink ribbon culture is that there has been created kind of a box, a breast cancer box with a pink ribbon on it. And there is one way to deal with breast cancer and you join the sisterhood and you come in and you're going to be fine. You're going to triumph. And yet there are many caveats to that, groups of people who are less supported, younger people being one group. And the idea that we could actually come forward and say there are diverse ways of dealing with breast cancer, of supporting one another, of bringing attention and awareness, that's something that needs to be infused within the culture in general (Gayle Sulik quoted on the Kojo Namdi Show, *"Pink Ribbon Culture" and Breast Cancer*, first aired on 7/11/2011).

In this section I want to briefly discuss the progression of several story lines and how the speakers in the related stories value the actions under consideration, through the

[illegible]

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Figure 4: Story Lines - The Breast Cancer Awareness Cluster



treatment, or recovery programming to create a promotional message. By using local people from Harlan County, the stories appear to be about experiences in the county, but the stories are actually “publicity from above” with the object being less about “encouraging reasoned debate than to promote an uncritical acquiescence to their publicized positions” (Magnan, 2006). Habermas calls this kind of promotional activity “manipulated publicity” and he argues that the use of this genre of public relations manages to promote a narrow private interest while giving the illusion of fostering critical reflection on some important societal matters (Habermas, 1987, p 177–194).

...the critical function of publicity tends to be replaced by the representative function of publicity of the old feudal order. Not only are private interests advanced in this way, but the state too adopts the practices of public relations in order to “sell” its policies to a relatively uncritical public. Thus, late capitalist society is refeudalized in two senses. First, through its structural transformation, precipitated by its own contradictions, the neat separation of the state from the social reproduction of society is destroyed. Second, and as a result of the first process, the use of public relations by the organized interests of late capitalism transforms the rational-critical function of publicity into the sophisticated manipulation of public opinion by powerful actors (Magnan, 2006, p. 32).

The modal verb “can” is one of the two main modal verbs used in the Breast Cancer

Awareness story cluster. The other highly used modal verb used is “will”; for the sake of brevity the focus here is on the use of “can” because of the way it demonstrates the positioning of cancer-related actors in terms of the situational resources (physical, psychic, social, technical) to act and the way this positioning further territorializes cancer-related activities within the apparent horizon of meaning related to ACS, even as the charity relies on HARH in many cases to be the physical site where ACS resources are actually deployed. The KWCSF is the other resource channel at work here and it is downplayed in the Hensley story mentioned above in favor of mention of the ability of HCHD to access private insurance payment because they have a qualified practitioner to deliver screening services. This message represents an appeal to middle-class women seeking screening services in the community, not an appeal to uninsured women receiving Medicaid, which is the focus of “Breast cancer screenings offered at health department”, the story from 10-12-2005 and analyzed in the previous chapter. Most of the ACS programs are focused on providing resources for those receiving treatment for cancer as opposed to those attempting to prevent cancer, offering little, if any, support for public health efforts to increase involvement with early detection and screening, or to reduce health disparities.

Sulik (2011) has accused ACS of contributing to the aesthetization tendencies in pink ribbon culture. The emphasis on awareness activities that spread the ubiquitous pink ribbons and other bright pink products, as well as programs like “Look Great...Feel Better” and “Reach to Recovery,” promotes a kind of traditional femininity that normalizes breast cancer. The aesthetization “Look Great...Feel Better” was sponsored by the Cosmetic, Toiletry, and Fragrance Association (CTFA) and the National Cosmetology Association (Sulik, 2011). The CTFA is the main trade association for the personal care industry, which spent \$600,000 in California to defeat the California Safe Cosmetics Act, the first state legislative act to require manufacturers to disclose to the state any product ingredients that are on state or federal lists of chemicals that cause cancer or birth defects (The Campaign for Safe Cosmetics, 2005). Further, SourceWatch () reports that ACS has remained silent on industry efforts to defeat the California Safe Cosmetics Act of 2005, denying that CTFA’s ten million dollars a year in donations has influenced its response. According to an article in the Sacramento News & Review:

The bill's proponents said that one of the new law's biggest obstacles was the silence of the ACS, the most powerful cancer-research and cancer-lobbying organization in the world. The ACS is now the second-largest charity in the world, with a net worth of over \$1 billion and an average \$1 billion in annual revenue (Sacramento News & Review, November, 2005).

"Reach to Recovery" was a program originally designed to persuade women that breast cancer was not a disabling handicap. It focused on normalizing a women's postsurgical appearance while also promoting conciliatory behavior with medical professionals. The distribution of temporary prostheses by the program served both to allow women to conform to their wardrobes while also making survivor-volunteers walking evidence of medicine's ability to "cure" breast cancer (Sulik, 2011). Promotion of ACS programs in relation to awareness raising is central to the messages in the HDE stories. As a matter of fact, after reviewing ACS's 2008 IRS Form 990, the independent, non-profit charity evaluator, GiveWell, found that ACS spent a relatively small portion of its funds on prevention (or, for that matter, on research, the activity it claims is the main focus of its fundraising activities) (Givewell, 2010). Most of its funds are directed towards "raising awareness" activities like Relay for Life and the patient support services that were programs mentioned in May of the Breast Cancer Awareness story cluster.

Michael Thun of the American Cancer Society has said that ACS views relationships with corporations as a source of revenue for cancer prevention, and that rather than suggesting this is a conflict of interest, the way to view it is as a "pragmatic way to get funding to support cancer control" (NewsTarget.com, Thursday, 09/08/2005). Critics have argued that the emphasis on treatment and related support programs rather than prevention by ACS is instead an effort to promote expensive cancer treatment methods like chemotherapy and radiation. In *Cancer-Gate: How to Win the Losing War Against Cancer*, Samuel Epstein (2005), a long-time ACS critic and former head of a Congressional committee on cancer, claims that the agency is willfully suppressing information about the environmental causes of cancer. According to Epstein, carcinogens can be found in pesticides, industrial pollution, materials used in plastic or reconstructive surgery, the water supply and many other everyday materials, yet ACS insists on focusing only on explanations of cancer that involve lifestyle and personal responsibility.

Of the twenty-three times "can" appeared in the story cluster, twelve occurred in the

Table 4: The Use of “Can” in the Breast Cancer Awareness Story Cluster

Can			
2003	Story Date	Exchange Type	
e cancer, and I'm dreading that day, but I hope I <i>can</i> reach enough women through preventative education	10/14/2003a	Activity	
h Department really helps," Turner added. "And we <i>can</i> also now bill private insurances for services pro	10/14/2003a	Competence	
ween women that's strong and true. I feel as if I <i>can</i> really relate to my patients, discuss their fears	10/14/2003a	Activity	
ing the disease and returning to a normal life. I <i>can't</i> stress enough how valuable cancer screenings ar	10/14/2003a	Possible request	
y not have any symptoms, annual cancer screenings <i>can</i> mean the difference of a possible death sentence	10/14/2003a	Knowledge	
tection because the simple, low dose breast X-ray <i>can</i> detect lumps as small as pinheads long before phy	10/14/2003a	Competence	
s small as pinheads long before physical symptoms <i>can</i> be seen or felt. And when breast cancer is detect	10/14/2003b	Knowledge	
breast cancer is detected in its early stages, it <i>can</i> be successfully treated 97 percent of the time.	10/14/2003b	Ability	
Harlan woman discovered cancer <i>can</i> strike people of all ages (This is the t	10/14/2003b	Knowledge	
er inner strength and beat the odds, and that she <i>can</i> call herself a survivor. She stresses the importa	10/15/2003	Ability	
d. Face reality. Go regularly to your doctor. You <i>can't</i> take your health for granted. You have to heed	10/15/2003	Prediction	
at age 58, Garrison has continually asked, "What <i>can</i> I do to help?" Her attitude is i	10/16/2003	Knowledge	
	10/17/2003	Competence (Negative)	
2006		Activity	
Appalachian Regional Healthcare Hospital, Messer <i>can't</i> help but to compare her breast cancer story to	10/17/2003	Competence	
women look for a lump or some kind of pain, both <i>can</i> be misleading. Only a small percentage of lumps a	11/1/2006	Knowledge	
e, which is quicker than an open surgical biopsy, <i>can</i> be performed in an outpatient imaging center. Dr	11/1/2006	Ability	
2007		Activity	
"We talk about what's going on, and you <i>can't</i> help but feel for them and think about it, but	11/1/2006	Knowledge	
here was nobody to talk to. "You <i>can</i> talk to your family, but a lot of the things you	6/25/2007	Ability (Negative)	
ily, but a lot of the things you need to say they <i>can't</i> really understand. When you have a support grou	6/25/2007	Knowledge	
When you have so much out there to live for, how <i>can</i> you not want to fight for it? We really need the	6/25/2007	Possibility	
2009		Knowledge	
That is the one main thing," said Garris. "You <i>can't</i> just give up the fight." Howev	6/25/2007	Ability (Negative)	
earlier detection, the disease and its treatments <i>can</i> still ravage the body. "One of m	6/25/2007	Activity	
of the breast or both breasts. The entire breast <i>can</i> be removed or only part of the breast may be remo	11/6/2009	Ability	
ody, your health. It's helpful, I think, when you <i>can</i> go to your doctor in good or bad times."	11/6/2009	Activity	
	11/6/2009	Possibility	

subset of five Breast Cancer Awareness Month stories from 2003 (see **Table 4: The Use of “Can” in the Breast Cancer Awareness Story Cluster**). Five of the twelve uses in the 2003 stories are oriented to doing things or getting things done while seven are oriented to exchanging knowledge. This second groups includes some emphasis on possibility and prediction, but mainly are used to promote the perception of ability, or are

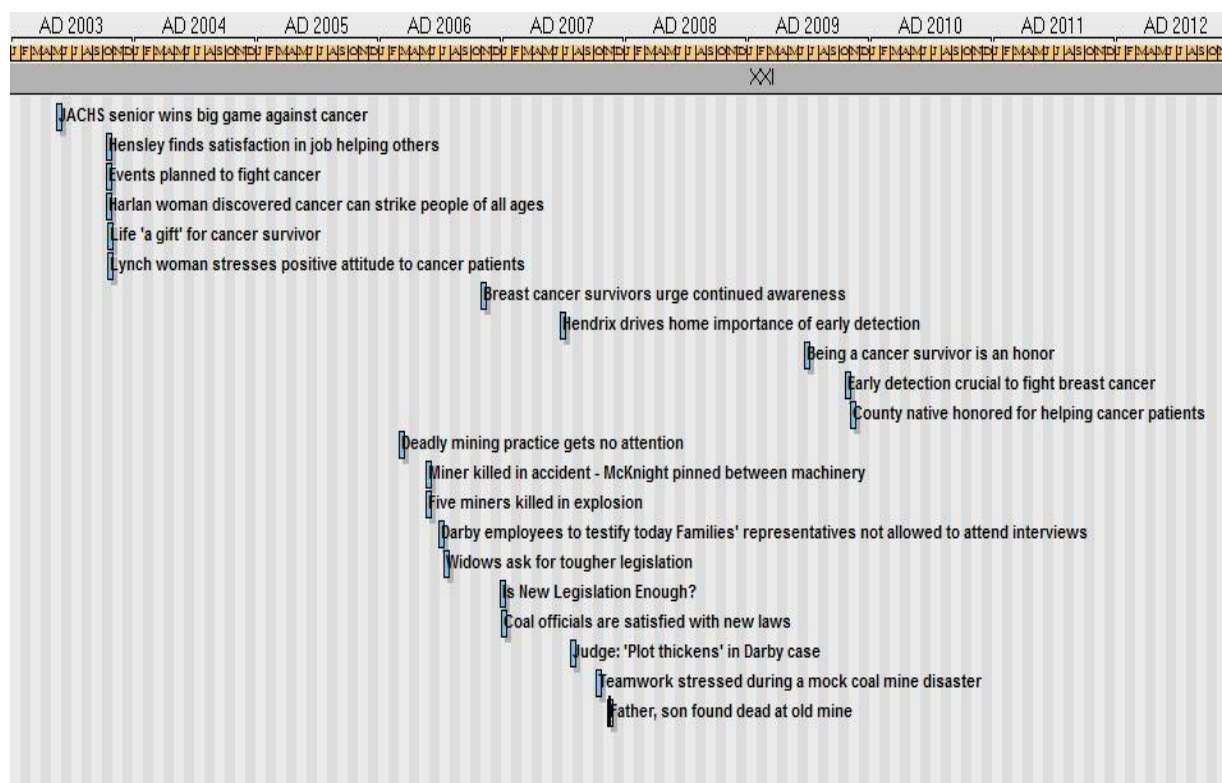
used to express the know-how that local service providers have acquired and internalized. Local service providers and ACS volunteers are, along with cancer survivors, valorized and shown to be committed to a particular truth about cancer as it fits with the broader Early Detection and Screening Advocacy culture of action. This emphasis on the narrow truth of the Early Detection and Screening Advocacy culture of action makes alternative voices, like those of people of color or from low income backgrounds, practically impossible to be heard above a form of promotional culture (Wernick, 1991) that continues to aestheticize the experience of women in relation to upper middle-class femininity (Sulik, 2011).

The Mining Accident Cluster and the Modal Verb “Will”

The modal verb “will” **is used** when a speaker or author is very sure about the claims they are making. “Will” is used as part of a definite statement, which means that one uses it when one is certain that a certain future action is going to take place (Palmer, 1990). When “will” is used, the speaker/author or the subject executing the future action is committed to its being carried out (Palmer, 1990). “Will be doing” is used to talk about something that will be in progress at a particular moment in the future, often events that are fixed and already decided. In some cases it is used as a kind of prediction about what is happening now (Palmer, 1990). “Will have done” is used to talk about what will have been achieved by a certain moment in time, to emphasize continuity in activity, or to predict what is thought to have already happened at present (Palmer, 1990). **Figure 5: The Mining Accident Cluster Contrasted with the Breast Cancer Awareness Cluster** organizes the Breast Cancer Awareness Cluster of stories as a timeline.

Eighteen of the thirty-five uses of “will” from the Mining Accident story cluster were contributed by two stories in the cluster, “Is New Legislation Enough? Coal officials optimistic, safety advocates hesitant” (12-30-2006), and “Coal officials are satisfied with new laws” (01-01-2007). **Table 5: The Use of “Will” in Two Stories from the Mining Accident Story Cluster** lists these eighteen will-phrases. The two stories are part of a subset of eight (of the ten) stories from the story cluster and a set of sixty-five stories about the Darby mine disaster that have appeared in the Harlan Daily Enterprise from 2006 to 2011. The eight stories were included in the samples drawn from the HDE for this study because they emerged from keyword searches for “environment”, “water

Figure 5: Story Lines - The Mining Accident Cluster Contrasted with the Breast Cancer Awareness Cluster



quality”, “sewer”, and “roads”.

The Darby Mine No. 1 disaster on May 20, 2006, killed five miners and left one survivor. The federal Mine Safety and Health Administration (MSHA) had issued 254 prior citations primarily for safety violations against the mine in the five years it was open under the same operator who owned the mine at the time of the accident (Washington Post, 1/17/06). In a surprisingly callous statement, the story states that the number of citations was said to be typical of the number of citations a similar operation might have incurred in the same time frame. Earlier that same year in January, a dozen miners were killed in an explosion at the Sago Mine in West Virginia. The 12-30-2006 and 1-1-2007 stories detail the passage of Kentucky Senate Bill 200 (SB 200), mining safety legislation that arose after record numbers of Kentucky miners were killed in accidents. At the national level in 2006, Congress passed the Mine Improvement and New Emergency Response Act (MINER Act). The MINER Act amended the 1977 Mine Act to require mine-specific emergency response plans in underground coal mines; it also

Table 5: The Use of “Will” in Two Stories from the Mining Accident Story Cluster

Examples of the use of <i>will</i> in HDE stories from 12/30/06 and 01/01/07
<p>Is New Legislation Enough Coal officials optimistic safety advocates hesitant 12/30/2006</p> <p><i>1. certain that the future action is going to take place</i> Kentucky and West Virginia lost a combined 39 coal miners this year, with 17 from the Darby and Sago mine disasters. Both have lost a combined 148 miners since 1993. Tuesday [<i>will mark</i>] the one-year anniversary of Sago, where 13 West Virginia miners were trapped for nearly two days. Only one miner survived the blast, much like Darby when only one of six survived a methane explosion.</p> <p><i>2. subject executing the future action is committed to it being carried out</i> It's the hardest thing I've ever faced. It still doesn't seem real, she said. She's hoping the coal mining deaths and legislation that followed in 2006 [<i>will spare</i>] other families the pain of losing a coal miner.</p> <p><i>3. used to talk about something that will be in progress at a particular moment in the future, often events that are fixed and decided</i> Bush said it is important to note that state officials also conduct other inspections in addition to its annual requirements. Those inspections range from electrical to roof control and ventilation checks. She also noted that the state has safety analysts who work one-on-one with underground miners and [<i>will be working</i>] more closely with mine foremen in 2007.</p> <p><i>4. used to talk about something that will be in progress at a particular moment in the future, often events that are fixed and decided</i> <i>5. subject executing the future action is committed to it being carried out</i> Bush said state officials [<i>will be focusing</i>] on implementing the new mine safety laws from 2006, but [<i>will pursue</i>] legislation where they see a need. Coal officials are satisfied with new laws 1/1/2007</p> <p><i>1. used to talk about something that will be in progress at a particular moment in the future, often events that are fixed and decided</i> <i>2. subject executing the future action is committed to it being carried out</i> Bush said state officials [<i>will be focusing</i>] on implementing the new mine safety laws from 2006, but [<i>will pursue</i>] legislation where they see a need.”</p> <p><i>3. used to talk about something that will be in progress at a particular moment in the future, often events that are fixed and decided</i> Bush said it is important to note that state officials also conduct other inspections in addition to its annual requirements. Those inspections range from electrical to roof control and ventilation checks. She also noted that the state has safety analysts who work one-on-one with underground miners and [<i>will be working</i>] more closely with mine foremen in 2007.</p> <p><i>4. certain that the future action is going to take place</i> Bush is also hopeful the new drug testing policy under House Bill 572 [<i>will produce</i>] positive results, though nearly half of the cases have been appealed. As of Wednesday of last week, 152 miners have been suspended under the law, Bush said.</p> <p><i>5. certain that the future action is going to take place</i> Caylor is most optimistic about the state's new drug testing policy, which he believes [<i>will go</i>] further to eliminate injuries and fatalities than anything else.”</p> <p><i>6. certain that the future action is going to take place</i> He's still a little speechless when it comes to talking about the incident and he really doesn't know how legislation from 2006 [<i>will affect</i>] this year and years to come.</p> <p><i>7. predict what is thought to have already happened at present</i> Bob Friend, deputy assistant secretary for MSHA, has been with the federal agency for more than 28 years. Like Caylor and Bush, he believes new legislation on the state and federal levels [<i>will have</i>] a positive impact on safety.</p> <p><i>8. certain that the future action is going to take place</i> He's comfortable with the provisions under the federal MINER Act, which he said he believes [<i>will knock</i>]</p>

2006's fatality spike down. He's also satisfied with MSHA's inspections requirements.

9. *used to talk about something that will be in progress at a particular moment in the future, often events that are fixed and decided*

10. *certain that the future action is going to take place*

It [will be] with proper enforcement that we [will see] the decline that we're all after, he said.

11. *used to talk about something that will be in progress at a particular moment in the future, often events that are fixed and decided*

12. *subject executing the future action is committed to it being carried out*

Also an optimist, Friend said the coal industry [will be moving] forward in reversing 2006's trend of fatalities and [will be focusing] on its ultimate goal - zero fatalities, injuries and occupational illnesses."

13. *certain that the future action is going to take place*

Stella Morris had to move from the home she shared with Bud Morris, though she's still living in Cumberland. She began 2006 by making funeral arrangements for her husband. She said she'll begin this year with a positive outlook. While coal officials [will remain] vigilant about saving lives, she'll remain vigilant about speaking up.

added new regulations regarding mine rescue teams and the sealing of abandoned areas; required prompt notification of mine accidents; and enhanced civil penalties. Kentucky SB 200 was in part a response to the Darby disaster and in part a response to the MINER Act. It included whistleblower protection to keep employers from retaliating against miners who report unsafe working conditions or who cooperate with investigating agencies. SB 200 made allowances for state regulators to more easily fine companies for safety violations and gave the commissioner of natural resources the authority to assess penalties of up to \$5,000. It also included provisions for two-way communication between the working section of the mine and the surface, escape maps posted or readily accessible to all miners and at the surface, emergency evacuation, action and firefighting plans at coal mines, escape drills for all miners every 90 days, and caches of self-rescuer devices in escape ways, spaced at intervals consistent with federal requirements.

The use of "will", with its implication of certainty, is paradoxical in this contentious social world. The likelihood that communities will be exposed to environmental carcinogens in their water and air is both a consequence of increased exposures related to Mountaintop Removal Mining and continued economic development practices that rely on otherwise declining employment in the mining sector (Hendryx, 2011; Hendryx & Ahern, 2008; Hendryx, Fedorko & Anesetti-Rothermel, 2010; Hitt & Hendryx, 2010). The mining industry has argued that increased government regulation has pushed them to discontinue using traditional mining methods and rely on Mountaintop Removal techniques instead. The complaints and accusations of the mining industry are interwoven

with an “ideology of sacrifice” (Bell, 2009; Bell & Braun, 2010; Bell & York, 2010; Connolly, 1981; Scott, 2010) that shapes regional masculine roles as family breadwinner, legitimates suffering and loss in the name of continued employment, suppressing discussion of alternative economies based on renewable energy sources.

This aversion to discussing the carcinogenic effects of mining resonates with similar concerns industry efforts mentioned earlier in the paper to defeat the California Safe Cosmetics Act of 2005. ACS denied complicity with the cosmetic industry even though it had accepted ten million dollars a year in donations from the Cosmetic, Toiletry, and Fragrance Association (CTFA) and the National Cosmetology Association (Sulik, 2011). In both social worlds, environmental concerns and the fear government regulators make discussion of relevant environmental exposures a “sensitive issue”. Coupled with the neoliberal strategy to rely on philanthropic and corporate giving rather than government funding via universal healthcare, there are buffers, the “breast cancer box with a pink ribbon on it, inhibits opposing voices from having a place in the discussion. Both social worlds become complicit in the hegemony of corporate influence to assure continued financing.

Conclusion

The centrality of some organizations, like Kentucky State Government, HARH and HCHD when all the local organizational actors are aggregated in a complete social network as represented in the Harlan Daily Enterprise, as well as the core status of these same organizations in associated block models suggests that they are positioned mainly through their repeated use across both cultures of action as preferred sources for local news. They are favored to provide answers when disruptions to daily life in Harlan County occur. Hence, these organizations and the stories they tell are important to figuring the “imagined community” that is part of the horizon of truth that validates and legitimates particular interpretations of what it means to live in the county. Their alignment with the mainstream early detection and cancer screening advocacy culture of action and failure to confront the destructive consequences of mining and support the cancer prevention and environmental activism culture of action assures that media representations will continue to frame issues in the public sphere in favor of hegemonic interests.

The two cultures of action, early detection and screening advocacy and cancer prevention and environmental activism, are represented in the *Harlan Daily Enterprise* as if they are two completely unrelated social worlds. The meaning horizon which delimits what is to be said and known, and which authorizes as true certain meanings and knowledges at the expense of others, is structured so that these two worlds rarely intersect. The politics of truth at play constitutes any debate as confined to the two social worlds. It allows no connection between the two public spheres. Ideologically, the early detection and screening advocacy, and the health-related social world it is embedded in, emphasize personal responsibility for one's health and defines the causes of disease in terms of unhealthy lifestyle. The promotional messages at the heart of the rhetoric of this sphere focus on family ties, particularly between mother and daughter. At the same time, that rhetoric also denies the presence of class and race by omission even as it holds the alleviation of health disparities as one of its central goals. Many critics of this culture of action have argued that this rhetorical practice deliberately diverts attention from environmental causes of cancer in support a "citizen-consumer" model that lauds consumption of potentially dangerous industrial products (King, 2008; Ehrenrich, 2010).

The local social world in Harlan County is dominated by the American Cancer Society, the Harlan Appalachian Regional Hospital, and the Harlan County Health Department. These three organizations are important as sources of "organizational personhood", legitimating those who are interviewed for the news as expert sources. HARH and the ACS dominate the domain in large part because they are able to use their resources to maintain professional public relations staff and "make" news as well as be part of the news. The local cancer prevention coalition is only mentioned in one news story, even though its membership includes representatives from each of aforementioned healthcare organizations, in large part because the coalition itself has fewer resources for its pursuits, making it unable to compete for media attention as some of its members do.

Coalitional politics among the organizations involved in the cancer coalition is evident in terms of participation in the year long cycle of local promotions and campaigns that define public cancer prevention activity. It includes paying tribute both to the miracles of modern biotechnical medicine and to support from local volunteers for the American Cancer Society. This kind of promotional activity is what Habermas (1989) calls

“manipulated publicity”. It is a public relations approach that refeudalizes capitalist society in two senses. First, through its structural transformation, precipitated by its own contradictions, the neat separation of the state from the social reproduction of society is destroyed. Second, and as a result of the first process, the use of public relations by the organized interests of late capitalism transforms the rational-critical function of publicity into the sophisticated manipulation of public opinion by powerful actors (Magnan, 2006, p. 32). Personal stories of cancer survival compliment the promotion process and serve as testimonials for the value of biotechno-medical intervention and for ACS programs. The survivor stories also justify the request for donations. The stories also act suggestively to recommend that other women follow the same course as that of the survivors, submitting to screenings regularly, hailing the female reader to identify herself as a “risky subject” (Klawiter, 2008).

The use of the pragmatic model operator “can” positions ACS to act in relation to the situational resources (physical, psychic, social, technical) available in the community. This positioning further territorializes cancer-related activities within the apparent horizon of meaning related to ACS, even as the charity relies on HARH in many cases to be the physical site where ACS resources are actually deployed. Local service providers and ACS volunteers are, along with cancer survivors, valorized and shown to be committed to a particular truth about cancer as it fits with the broader Early Detection and Screening Advocacy culture of action. This emphasis on the narrow truth of the Early Detection and Screening Advocacy culture of action makes alternative voices, like those of people of color or from low income backgrounds, practically impossible to be heard above a form of promotional culture (Wernick, 1992) that continues to aestheticize the experience of women in relation to traditional femininity (Sulik, 2011), a role identity foreign to many women in eastern Kentucky.

The cancer prevention and environmental activism culture of action, on the other hand, typically is structured by story lines related to environmental crisis, reactions by the local citizenry to the costs of the crisis, and attempts to remedy the crisis either through engineering projects or legal intervention. The social world of this culture of action is clearly divided in terms of those that support the coal industry and those that do not. The coal industry is represented in these stories by the various small operators who mine coal

sites for larger coal corporations, while the opposition to the industry is typically represented by Kentuckians for the Commonwealth (KFTC). These stories also include the ongoing presence of state and federal regulatory agencies and the Kentucky courts, all of whom appear regularly to be asked to mediate disputes about the ongoing consequences of mining activities in the region. Even though KFTC has been incorporating public health knowledge into its arguments against coal mining in the region, this information never surfaces in the HDE stories.

The politics of truth at play in the larger social world of the cancer prevention and environmental activism culture of action is one where competition is more overt. Both sides compete to define the issues not only in the media, but also through competing legal decisions and policy action. In this sphere, overt statements by citizens and government officials acknowledging the detrimental impact of the mining on the region are common place, yet these statements appear to be minimized or even forgotten when local environmental opposition voices concerns about the effects these practices are having on residential properties or on the public health. This suppression of conflicting views resonates with failures by the major cancer charities like ACS to confront industrial and environmental impacts in other industries like cosmetics.

Chapter Eight: Appalachian Identity and Cancer Prevention in Eastern Kentucky

Introduction

The social rituals of cancer prevention promotions rely on a narrative logic that encourages readers/listeners to identify with certain “exceptional” subject positions that embody the heroic characteristics necessary for enduring cancer-related services and through trusting one’s service provider. At first glance, this statement would appear self-evident. Of course, medical personnel are using health promotion narratives and rituals to rise to the challenges that an illness like cancer poses for a patient as well as for those who deliver services. Yet, as Sheryl Burt Ruzek (1997) argues, formal behavioral risk reduction programs tend to reflect what medical personnel are prepared to treat or prevent rather than what might be changed to improve the quality of life and well-being for us all. In this way, mainstream cancer prevention activities require a context where there is a political will to support the changes that are recommended. My broader purpose throughout this dissertation has been to explore what political will, what “prevailing social attitudes” (Duffy, 1992), are affecting the focus of health promotion in central Appalachia, particularly in the face of efforts to facilitate local participation in cancer prevention promotions. Throughout this dissertation, these “prevailing social attitudes” have repeatedly been shown to be carrying on a Neoliberal economic and political agenda.

What I have attempted to do in the preceding chapters has been to open up regional media texts alongside discussion of cancer prevention coalition networks so as to explore some of the variety of voices and interests at stake in discussions of cancer prevention at the local level in a small part of the Appalachian region. These voices are not simply concerned with the narrow issue of cancer prevention, but also the economic and social well-being of the community and the distribution of resources needed to assure that well-being can be assured. Cancer prevention is one of several issues, along with drug addiction and environmental pollution, being ameliorated, at least in part, through the development of local coalitional politics to create a limited consensus in local governance. The governance approach is based in a Neoliberal harmony model of power with an emphasis on individual, rather than collective, responsibility in lieu of a

diminishing regulatory state and shrinking social safety net.

Together, the objects of analysis in the earlier chapters correspond to three of the four levels of analysis in Levi-Strauss's (1983) structural study of the Asdiwal myth.

First, the physical and political geography of the Tsimshian country, since the places and towns mentioned really do exist. Second, the economic life of the natives which, as we have seen, governs the great seasonal migrations between the Skeena and Nass Valleys, and during the course of which Asdiwal's adventures take place. Third, the social and family organization, for we witness several marriages, divorces, widowhoods, and other connected events. Lastly, the cosmology, for, unlike the others, two of Asdiwal's visits, one to heaven and the other below the earth, are of a mythological and not of an experiential order.

Chapters two and three examined, among other things, economic features of cancer prevention by understanding how the coalitions are organized to facilitate the flow of Medicaid funding and public fund-raising in support of cancer prevention via the Kentucky Women's Cancer Screening Program. Chapter four examined geographic features underlying how referrals are exchanged and patients potentially move between providers. Chapters five and six deconstructed media stories to examine the sociological dynamics shaping public perceptions of cancer prevention by exploring competition between actors and organizations for attention to their definitions of cancer prevention issues. This chapter adds an analysis at the cosmological level of cancer prevention themes.

In the following, the focus is on a subset of twenty-six stories from the Harlan Daily Enterprise news story set which I call "Profile" stories. The stories all "profile" persons from the Harlan County, Kentucky area who have done some kind of exceptional activity related to cancer prevention and treatment in the region. In doing so, the stories construct ideal identities among health care providers, patients and their support networks. In the following section, I will relate the types of ideal identities constructed in the stories to broader ideological commitments having to do with the class and the gendered nature of regional economic identities (Oberhauser, 1995; Rome, 2006; Scott, 2007; Scott, 2010; Bell, 2009; Bell & York, 2010; Bell & Braun, 2010). I will attempt to theorize features of these identities that support specific identity solutions to the production/consumption contradictions discussed by Crawford (1985; 1992; 2000) in earlier chapters. I will then briefly discuss the methods by which I developed my analysis, followed by and

exposition of the thematic elements of the stories that use class and gender to mark out ideal identity features. I will conclude by examining how the heroic identities serve a broader mythic view of modern biomedicine as a desired outcome of Modernity and the capitalist treadmill of production (Bell & York, 2010).

Mapping Appalachian Identities as Part of a Mythic System

This chapter is only meant to provide an intuitive exploration that loosely maps features of several versions of Appalachian identity together as a mythic system. Since at least the 1980s, transformation and liberation through the pursuit of health have been articulated as a kind of market freedom, in terms of the “class-as-lifestyle” myth, and are individualized and actualized through consumption, reconceptualizing the health consumer as a kind of especially remarkable person in a neoliberal universe who exercises political as well as lifestyle choice in a public marketplace rather than a public sphere.

As the discussions of solidarity and power in the Register of local media discourse in earlier chapters have shown, Appalachians become the heroes and villains and victims in dramas about how cancer disrupts the lives of people from the region. Appalachian communities, like those represented in the various Harlan County stories, are defined as communities at risk, restored to equilibrium in part by the availability of biomedical intervention, but also through the strength of its other valued institutions: schools, county government, and neighbors and family. The stories teach readers what attributes are required for successful adaptation within these institutions.

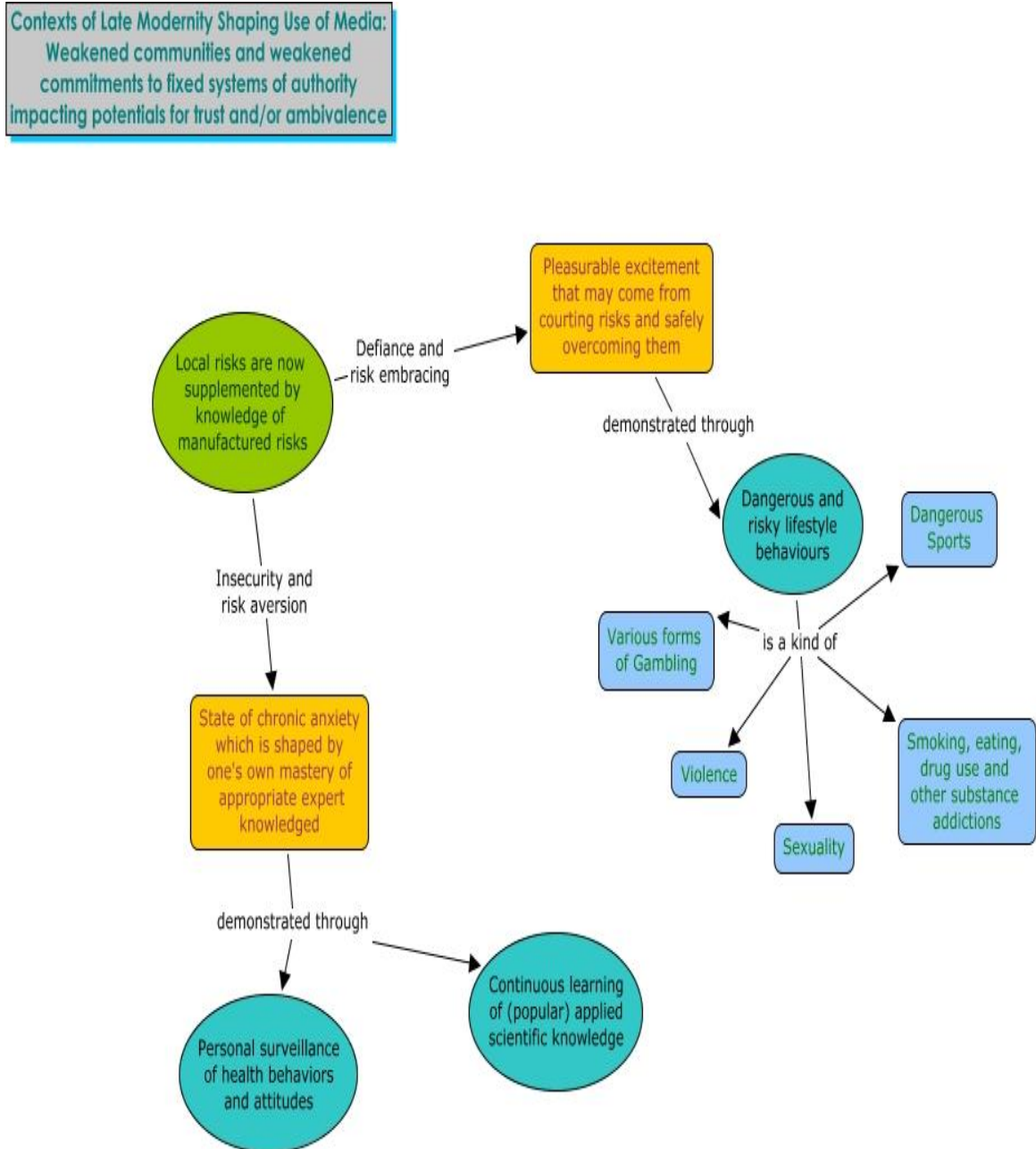
Cancer prevention narratives purport to tell personal stories of exceptional individuals, either professionals or lay persons. They tend to follow a generic script that supports the “early detection” and “discourse of hope” narratives that ground mainstream stories in the institutional practices of cancer prevention and treatment. As discussed previously, the mainstream cancer prevention and cancer treatment narratives valorize practices that deploy biomedical technical expertise. The central hero of the professional cancer drama is the physician; and his supporting cast includes nurses and allied health service professionals who act as “serviceable others” (Morrison, 1993; Sampson, 1993), characters who support the construction of doctor as hero. Within this storyline patients and their families are framed as victims of cancer in need of the guidance, expertise, and

leadership the physician supplies. Patient narratives offer another collection of subject positions where struggle against cancer within the constraints of biomedical intervention results in cancer patients who attain hero status as “survivors.” The caveat is that they maintain the prescribed stoic resolve to follow prescribed treatment routines, keep a positive outlook, and participate in the continuing rituals of pink ribbon culture. Though not openly critical or judgmental about other narratives, the discourse rarely takes up cases that do not follow the generic script. Alternative stories concerning the invasiveness of treatment or questioning the “brightsiding” logic of the mainstream cancer ideology rarely, if ever, appear in mainstream publications (Stacey, 1997; Ehrenreich, 2009). As Ehrenreich (2009) has discussed, mainstream cancer recovery stories can become quite “over the top” in making claims about the positive and self-transformational impact that can be expected from cancer treatment, while being equally critical of voices that question the mainstream discourse.

I have previously suggested that actors who engage in transgressive negative health behaviors, such as addiction, overeating, and, indirectly, individual level polluting, like throwing trash in local streams, create, through their risky, unhealthy behaviors, additional strains on regional safety nets that health- and environmental-related coalitions like the cancer prevention coalitions, UNITE, and PRIDE attempt to manage. In this sense, these individuals become serviceable others (Sampson, 1990) to the broad heroic designs of local coalitional politics. They are serviceable others to the extent that their addictive or destructive behavior reinforce negative regional stereotypes about Appalachians as “white trash” (Newitz & Wray, 1997; Wray, 2006). They are outside the moral community of those who fulfill their “duty to be well” (Greco, 1993). As a result, fail to adhere to the prescribed rituals of health and redemption, becoming “throwaways” that are no longer deserving of safety net assistance (Watkins, 1993; Jarosz & Lawson, 2002).

These trajectories of meaning-making are reflected in the branches of the diagram depicted in **Figure 1: Giddens and the Context of Media Stories in Late Modernity** (Giddens, 1990; 1991; 1992; Silverstone, 1994; Seale, 2002). In this line of theorizing, Modernity weakens communal ties by weakening systems of traditional authority and meaning. In turn, there are impacts on a community’s ability to trust and manage

Figure 1: Giddens and the Context of Media Stories in Late Modernity



ambiguity, particularly as perceptions of local crises and disruptions are supplemented with media representations of “manufactured” crises from “elsewhere”. Though many people seek expert information to supplement their abilities to self-monitor health behaviors and engage in continuous learning of expert knowledges, they may also derive pleasure and excitement from courting risks. As such, those that court risks may engage in an array of risky behaviors including gambling, violence, unprotected sex, overeating,

drug or alcohol abuse, or other risky behaviors. Giddens (1990; 1991; 1992), Silverstone (1994), and Seale (2002) offer a way to understand negative health behaviors and bring them into relationship to positive health behaviors. Risk courting arises from the kinds of everyday anxieties and ambiguities that emerge in the face of the contradictions of Modernity, contradictions between production and consumption that Crawford (2000) describes.

To extend this line of reasoning, I turn to Hall (1973; Hall & du Guy, 1996) and Morley (1992) to argue that the cancer prevention stories in the Harlan newspaper guide local audiences towards the preferred reading of cancer narratives by offering certain subject positions and by presenting, via various narrative devices, how the defined positions and narrated events should be understood. Recipients of media stories base their understanding of media stories on their semiotic interpretations, utilizing internalized interpretative frames to encode and decode what they experienced (Hall, 1973).

These preferred readings typically make certain ideological commitments and may embrace particular expert discourses and the solutions offered by those experts. The process of reading does not necessarily lead to a preferred reading, but rather can result in one of three types of interpretations which Hall labeled as preferred, negotiated, or oppositional readings of media productions (Hall, 1973). The process does not ensure a final fixed meaning for stories about cancer prevention, but, rather, narrows down the text's meaning potential (Törrönen, 2001a). Preferred readings of texts might better be understood as one point of intersection for meaning construction, with the interpretive possibilities of the recipients understood in nuanced ways that can exceed any one of the three categories of preferred, negotiated and oppositional readings originally posited by Hall (Törrönen, 2001a).

Emotional Bonding via “Class-as-Lifestyle”

Identities are points of temporary attachment to the subject positions which discursive practices construct for us (Törrönen, 2001a). Articulating the subject in a specific discourse requires investment in the subject position that a specific text is offering. The preferred reading of a text 'hails' us to identify with particular positions, discredits others, and may avoid addressing some positions altogether. Profile stories are ones that try, more than any other kind of story, to facilitate identification with heroic characters by

defining and clarifying identity in cancer prevention discourse. They provided justification for compliance with medical practices through a discourse of dignity and greatness in the face of severe adversity (Boltanski & Thévenot; 2006; Sulkenen, 2011). As I read Profile texts, I repeatedly asked, “What subject positions are being offered in this text?”; “How are audiences being hailed to invest in some positions and not others?” and “Are there positions that are implicated, but are conspicuous in their absence?”

Newspaper discourses using standard story forms provide a means through which consensus, resonance, and coherence are maintained over time, binding the different scales of affiliation and polar oppositions among thematic domains together into a sense of regional membership. In a word, they are mythical. They operate as transitional objects that assure otherwise anxious audiences that a level of ontological security is being sustained by community leaders (Seale, 2002). They also interpellate, or hail, audiences to identify with certain preferred readings of the stories they tell. Hailing is grounded in reference group standards associated with pink ribbon culture. As I have discussed earlier, these standards define everyone as a "risky subject," are highly racialized and gendered, rely on intergenerational nostalgia and sympathies, and understand the ultimate medium of Civil Society to be that of Money and consumption. Femininity is defined in terms of a woman's beauty and sexuality and expressed through conspicuous display of pink products such as tee-shirts, cosmetics, and bumper stickers. Cancer prevention coalitions themselves are better defined as politically engaged social infrastructures rather than coherent communities and, as such, are better understood to be calibrated to different scales of social influence than a community generally. They include varied and cross-cutting political affiliations that go beyond a given local community.

As seen in the previous two chapters, the local cancer coalition was unable to compete with more powerful organizations for media attention. Affiliations with the coalition were invisible once powerful members entered the realm of media public relations, managing their own organizational status rather than promoting the collective will of the coalition. The elevation of cancer prevention standards to the status of common sense fractures the illusion of a unified local “community” through the way they make a fetish of “community” (Featherstone, 2001).

According to Anderson (1991), the advent of printed daily newspapers made it

possible for modern nations to imagine themselves as national communities. This “imagined community” allowed individuals unknown to one another to develop a sense of belonging and membership in the nation state because they know that others in the nation were engaging in the shared rituals of newspaper reading and reflection on the stories and information these stories entailed. Reading the newspaper allows people to feel a sense of permanence within a nation that has both a past history and a future - in the terminology of Törrönen (2001), Walby (2001) and others discussed in the last chapter - they derive continuity through engagement with storylines that tie preferred readings of the past to projected versions of the future advocated by competing reference groups. Gamson (1990) would say that people pursue, then learn to use, various “conversational resources” from media as well as from personal experience and from their culture. These resources aid in handling the disruptions of everyday life that are encountered on a day to day basis. In the Harlan Daily Enterprise stories, the available conversational resources make it very unlikely that a reader will find connections between public health concerns about cancer and environmental issues related to mining. They are also very unlikely to realize a local cancer prevention coalition exists in the community at all.

The discussions of Paasi’s (2006) work on regional identity from earlier chapters can be understood as related to Anderson’s seminal work at a meso-level scale, while the way a sense of belonging is discussed as being at the heart of the storytelling neighborhoods offers a conceptualization of how micro-, meso-, and macro-level networks of discourse tie together via local story telling interests (Ball-Rokeach, Kim, & Matei, 2001). From these various perspectives, local news stories can be said to “interpellate” or “hail” readers in ways that position them as regional and community members, but aligned with networks of relationships that may or may not embrace preferred readings of shared stories. Opening up the newspaper texts in ways that deconstruct their apparent unity and examining competition among various voices for media attention about social issues related to cancer prevention allows me to explore how readers are guided toward preferred readings.

Seale (2002), following Giddens (1990; 1991; 1992) and Silverstone (1994), understands subject positioning as part of a broader process of meaning making that helps

to establish and maintain “ontological security” in communities of people, with the choice of readings of stories offering audiences membership in a variety of communities based on reading preferences which come to shape the boundaries of “us” and “them” experienced by a particular community member. Media stories in effect become “transitional objects” that aid readers in managing existential anxieties that arise from disruptive events (Silverstone, 1994). Boundaries are created through perceptions of membership (“insiders” and “outsiders”), political ideological commitments (“conservatives” and “liberals”), homophily (“folks like me” or “different from me”), or other social categorizations, as the reader utilizes the categories in patterns of preference to make sense of the intersubjective ground of local coalitional politics. As discussed previously, membership carries obligations and expectations of coalitional alignments that imply support for clusters or networks of positions and perspectives, with audiences negotiating identification and commitment in the process of gaining understanding of how storylines include explanations and solutions to disruptive events. The negotiation of membership in various communities may involve choosing other readings that are “negotiated”, or even “oppositional” to the preferred readings of story authors (Hall, 1973; Morley, 1980; Törrönen, 2001) and can carry different valuations of individual or communal responses to disruption (Gamson, 1990). Media community memberships, along with the social ties one has in one’s everyday life, come to constitute and are constituted by the everyday rituals and routines that make up one’s lifeworld. The smallest exchanges can be understood as micro-rituals of boundary negotiation that carve out one’s social space.

The ordering and re-ordering of affiliations in these micro-rituals is a mechanism that has been in transition as traditional industrial labor has been segmented, realigned, and in some cases, dismantled in relation to growing service sectors of employment (Watkins, 1993; Jarosz & Lawson, 2002). One outstanding feature of the transition includes reorganizing labor in terms of gender, with much of the male industrial labor pool experiencing ever increasing job insecurity and unemployment even as the service sector requires more and more women to enter service sector employment (Scott, 2010). Another feature of the transition has been to reframe class as a lifestyle choice rather than an economic and structural location in the social order (Watkins, 1993). Along with

changes in the composition of the labor force, consumption has at the same time become not only an economic category under this transition, but a gendered social space which redefines class as a lifestyle choice. “Class-as-lifestyle” destabilizes historic gender identifications and obscures growing tendencies to make various groups of workers obsolescent as sectors of the economy restructure or disappear altogether. This is particularly acute in discourses about poor whites. “White trash”, “cracker”, and “redneck” become symbolic designations that mark poor whites as one of the obsolete populations in the changing economy that is moving away from male-dominated industrial labor and further into female-dominated service and information exchange as its primary economic activities. Anxiety about this transition has been exploited in Central Appalachia by efforts on the part of the coal industry to frame the region’s economic well-being in terms of patriarchal relations characterized by the importance of the coal mining male breadwinner and to create a political atmosphere that continues to make confronting the public health effects of coal mining a sensitive issue (Bell & Braun, 2010; Scott, 2010).

In this context, “health” emerges as a symbolic medium through which one confirms one’s fitness to be identified as a member of the politically symbolic middle class. As Sulkenen (2009) has suggested, social bonds in this era of consumer capitalism are based not simply on shared ways of life embedded in structural positions and based on one’s place in one production sector or another. Instead, lifestyle has become “a bond that connects individuals in very complex, extensive, and intermediated networks of consequences (p. 4)”. Wasteful, corrupt, or self-destructive activities put strains on support networks that are part of community safety nets. Coalitional politics about health care at the local level have become negotiations among individuals and agencies that must manage scarce safety net resources and hence must make decisions about how to distribute the risks posed by those whose pleasures have particularly devastating consequences on individual as well as the public health. “Health disparity” operates as a euphemistic trope that uses “class-as-lifestyle” discourse to obscure politically sensitive issues like the efforts of employers to externalize healthcare costs as individual health insurance as employment-based insurance plans disappear with the transition to “flexible” service sector employment. Another politically sensitive issue masked by the

“class-as-lifestyle” myth and the euphemism “health disparity” involves the ways various interest groups in the healthcare sector seek to increase profit taking through strategic deployment of market-based solutions in healthcare financing.

According to Evans (1997):

Current interest in market approaches represents the resurgence of ideas and arguments that have been promoted with varying intensity throughout this century. ... Yet international experience over the last forty years has demonstrated that greater reliance on the market is associated with inferior system performance—inequity, inefficiency, high cost, and public dissatisfaction ... market mechanisms yield distributional advantages for particular influential groups. (1) A more costly health care system yields higher prices and incomes for suppliers—physicians, drug companies, and private insurers. (2) Private payment distributes overall system costs according to use (or expected use) of services, costing wealthier and healthier people less than finance from (income-related) taxation. (3) Wealthy and unhealthy people can purchase (real or perceived) better access or quality for themselves, without having to support a similar standard for others (Evans, 1997, p. 427).

The continued impact of the coal industry on shaping the economic identity of the region (Bell & Braun, 2010; Scott, 2010) appears to obscure declining employment in the coal industry and the rise of female employment in service sectors. The failure of regional public health to develop “environmental competence” (Ahern & Hendryx, 2008) and begin making stands against the continued externalization of the public health costs of coal mining questions the notion that the extensive cancer burden of the region is due merely to gaps in knowledge about cancer among the general public. The interlocks between these dynamics shape the production/consumption contradictions in which health promotion rituals are planned and implemented in the region, prescribing the development of coalitional politics as a means to encourage local decision making about the distribution of ever-shrinking safety-net resources, while limiting the moral authority of the coalition to address and redress systemic injustices.

Being seen as someone who has the means to consume “(real or perceived) better access or quality” healthcare services as they are needed marks a person as economically stable and secure, and hence, also has a status element to it. Anxieties about the country’s ability to sustain this status structure has been seriously in question in recent years, as evidenced by the high levels of anxiety and frustration that emerged during the healthcare reform debates that were underway in 2009 when this project was being started. The

power of special interests who have been promoting market approaches to healthcare financing to dominate media storytelling drowned out the fact that medical problems contributed to at least 46.2% of all bankruptcies (Warren, Himmelstein, Thorne & Woolhandler, 2007). Seale (2002) points out that there are minor waves of anxiety and insecurity that are part of conversational exchanges as well as the use of media. Being able to mark one's self as a "properly moral and competent" human being is part of the emotion work that is embedded in negotiating social bonds to various real and imagined communities and expressed in the identification with, performance of, and commitment to different subject positions (Sulkenen & Törrönen, 1997).

As mentioned in the previous chapter, Thompson (1995) discussed how the forms of societal organization where dialogue and face-to-face communication are no longer viable instruments for day-to-day democracy, have been dramatically altered through expanding electronic forms of communication (Örnebring, 2004). One response to this increasingly competitive situation has been increasing tabloidization of the news (Langer, 1990). For Langer (1990), the tabloidization of media involves the use of generic conventions that interpellate audiences directly as "us" in ways that traditional hard news and "objective" information giving does not. Stories that focus on mundane everyday activities, whether preformed by celebrities or "just folks", are contrasted with stories about sensational and extreme events that put communities at risk. Through these standard story forms, heroes, villains, and victims are positioned. Langer argues that while the sensational events that occur in community at risk stories typically upset the equilibrium of the community, stories about mundane events are used to re-instate "normal" cause-effect relations, and thus, community equilibrium. Stories about communities of risk construct disruptions in the community in terms of both an actual description of the events of the disruption and in terms of the "disintegration", to use Langer's term, of normal causality. Langer's (1990) analysis of tabloidization in mass media news extends Hall (1973; 1996) and Morley (1992) further by creating a cosmological template against which to examine how the collages of stories provide a mythological ground for the news. It is at this mythic level that ontological security is re-established by resolving thematic and ideological contradictions.

The stories discussed in chapters five and six can be understood not so much as factual

accounts of events in Harlan County, but as the re-telling of mythic standard stories about the heroic activities of exceptional persons in the region. The mundane coalitional politics are retold so as to re-contextualize them in terms of winners and losers, heroes and villains. Cancer is represented as a villain to be defeated. When it is represented as an outcome, it is depicted as an outcome of negative health behaviors instead of a possible result of industrial pollution. Success is achieved through adherence to prescribed treatment rituals, rituals which allow them to transcend their old identity. They become heroic citizen-consumers.

Both Seale (2002) and Langer (1998) deploy structuralist notions of interpellation and subject position to identify objective features of the structures of meaning in news stories, including health news (Törrönen, 2001; Sulkenen, 2002), that can guide an “idealized reader” to identify with preferred readings of the stories. This allows them to illustrate the commitments of ideological arguments underlying preferred readings as they are shaped and reshaped to fit into the generic structures of standard story forms. It is this objective recontextualization process embedded in news making that constitutes the “public idiom” that codes news making over time (Hall, 1973; Langer, 1998; Seale, 2002). The ‘public idiom’ in HDE newspaper stories constructs a world essentially made stable and predictable, able to withstand temporary disturbances without upsetting the sense that there is an underlying permanence to the community. Coalitional politics operates as a sub-text here by assuring that a harmony model of power is assumed to be at work among members of the medical social world.

The “public idiom” that news makers use in the language of news also “translates” the opinions of powerful positions to audiences as “people of ordinary sense”, making temporary identifications with different subject positions a negotiation of (1) the boundaries between ‘us’ and ‘them’ through categorizations which spatialized aspects of identity construction; (2) orient persons to values of action through story lines, thus creating a temporal aspect of identity construction; and (3) effect the proper engagement with, and points of view about, the matters under question via positioning, establishing a positional aspect of identity construction (Langer, 1998; Törrönen, 2001)

In the current politics of Neoliberalism, “common sense” naturalizes the move towards a “transnational service economy based on informational technologies and the

ascendency of consumption” (Jarosz & Lawson, 2002) in part through a discourse of “class-as-lifestyle”. Part of this idiom paints upper, middle, and lower class behavior in terms of consumption and choice rather than structural location based on one’s place in the employment and wage hierarchies of the region. Common sense understanding often positions rural working class whites as obsolete, marking population groups like Appalachians as potential “throwaway populations” because of their obsolete position in the current service economy and the ways that low income levels diminishes power to consume (Watkins, 1993; Jarosz & Lawson, 2002). Class position is destabilized in this discourse by painting consumption choices as expressive of one’s tastes rather than one’s place in the stratification of society. The “class-as-lifestyle” logic “simultaneously reassures middle classes that they are different from poor whites and obscures the material processes of social power and restructuring that produces the harsh realities of poverty” (p. 10). Wage earning is expected to result in near continuous consumption, and through this consumption behavior, one’s identity as a member of the middle class is maintained. Those in poverty fail to contribute to this process of cultural reproduction, whether through obsolete skills limiting their value in the workplace or through an inability to consume at meaningful levels. As we have seen in previous chapters, even though the mandate of local cancer prevention coalitions is to address “health disparities” in the region, this message is lost on pink ribbon promotions that emphasize instead fund-raising.

I have been arguing that discourses of survivorship and recovery come to incorporate this “class-as-lifestyle” language when public discourse is colonized by institutional and or market forces. These forces disembody public discourse’s spatial (classificatory) and temporal (storylines and plot) grounding in the Lifeworld and recontextualizes them in the service of a Neoliberal political and economic agenda. The emergence of the citizen-consumer subject position as the default model of democratic agency, the push to force non-profits to operate “like a business”, emphasis on fund-raising, excessive and unending selling of pink ribbon culture, and trendy representation of the heroic cancer survivor as achieving self-transformation through positive thinking, are all part of the ideological colonization that attempts to distract us from the failure of the cancer industrial complex from “curing” cancer in spite of fifty years of research, the

breakdowns of the U. S. healthcare system that propagate inequity and sky-rocketing costs through sectors of the social structure, and the continued denial of environmental and industrial-based risks from modern technological production of energy (Hendryx & Ahern, 2008), food (Breast Cancer Fund, 2009b), and consumer products like make-up (Breast Cancer Fund, 2009a). The harmony model of power that underlies this approach to cancer prevention and control is structured to avoid confronting class-based inequities that make access to care available to all as well as fail to address realistic concerns about environmental hazards affecting the cancer burden of the region.

Consumer Myths Concerning Healthcare Consumption

“Class-as-lifestyle” myths mark a transition in the composition of the labor force from male-dominated industrial labor to a predominance of female service sector employment, reframes class as a lifestyle choice rather than an economic and structural location in the social order, redefines consumption as a gendered social space which further redefines class as a lifestyle choice, destabilizes historic gender identifications, and obscures growing tendencies to render various groups of workers obsolescent as sectors of the economy restructure or disappear altogether (Watkins, 1993; Jarosz & Lawson, 2002). This symbolic domain operates as a moral meta-language to provide a technological fix for ambiguities between production and consumption as the nature of work and employment transitions from the post-WWII industrial economy to a neoliberal service-based economy (Watkins, 1993); regionally, it also resonates with the ideological agendas of the coal industry in Appalachia. “Lifestyle” as a discourse used in cancer prevention is not the sociologically nuanced concept as developed by Veblen(1899), Weber (1946, 1947), Simmel (1990), and others, but appears to be a marketing term that defines how populations are to be segmented for marketing purposes (Plummer, 1974; Hirsch, 1976). As a result, the concept has become detached from many of its sociological connections to class, referring instead simply to patterns of everyday commodity consumption without consideration of the constraints stratification and structural position place on behavior.

Healthcare services are part of a healthcare sector that is now 18.2% of US GDP in 2011 (National Coalition on Health Care, 2011). One system for marketing services to population involves segmenting based on intracultural variation, otherwise known as

"microcultural" differences (Sirsi, Ward & Reingen, 1996). Their concern is the interrelation of the constituent aspects of culture in local groups through which larger patterns of cultural sharing are enacted. These aspects of cultural sharing involve individual, social and cultural processes that affect consumption decisions. Both corporate producers of "pink" products and individual consumers who purchase them use microcultural frames of reference that include therapeutic self-improvement and moral triumph to interpret their consumption experiences and to construct meaning-based linkages between their motivating values and the consumption goals being pursued. This thematic material has not evolved overnight but is a current manifestation of marketing themes that have been around since the beginning of the 20th century.

From its fin-de siècle origins among the affluent and well-educated, therapeutic self absorption has since spread widely, concentrating in the professional classes but reaching far beyond them ... the therapeutic world-view is not and never has been tied to formal regimens of psychotherapy. It is a constellation of concerns about self, energizing a continuous, anxious quest for well-being. From the therapeutic worldview, well-being is no longer a matter of morality but of physical and psychic health. And health is often defined in terms of spurious "normality," smooth adjustment, ceaseless growth, and peace of mind ... the therapeutic world-view is both a source and a symptom of the continuing evasive banality in modern culture....What begins in discontent with a vapid modern culture ends as another quest for self-fulfillment the dominant ideal of our sleeker, therapeutic modern culture. The effort to recreate a coherent sense of self seems fated to frustration. Every failure inaugurates a new psychic quest until the seeker is embroiled in an interminable series of self-explorations. (T. J. Jackson Lears, *No Place of Grace*, quoted in Thompson, 2003, p. 81)

The intersection of greatest interest for this chapter is that which aligns individual consumption for the sake of self-gratification by consumers of cancer prevention services with the social forces shaping "virtuous" cause marketing of breast cancer prevention (King, 2006). This intersection results in the construction both of organizational identities as benevolent corporate citizens who support the "perfect cause" of cancer prevention and individual identities as citizen-consumers who honor those suffering with cancer through the consumption of "pink" products.

In the current postindustrial socioeconomic order, there is increasing interpenetration of the marketplace into all facets of everyday life, creating a diverse array of health consumer microcultures (Thompson, 2004; Thompson & Troester, 2002). Two sets of

preferences are apparent, though not clearly separate, in the health marketplace - those who favor traditional biomedical services and those who desire alternative medical services. The fragmented microcultures consuming these services exhibit distinct patterns of socially shared meanings and practices which not only include treatment for the disease itself, but also lay claims to other realms of therapeutic value, including spiritual transcendence. The cultures of action involved with cancer prevention discussed by Klawiter (1998) have resonances with these microcultures of consumption. Marketing messages for healthcare, then, often hail the citizen-consumer with messages that appeal to both those interested in mainstream medical intervention as well as those for whom alternative medical interventions have appeal.

This means that there are similarities between the citizen-consumer invoked by cancer prevention and Ray and Anderson's (2002) Cultural Creative class. Their data suggested two worldviews and sets of values competed for dominance in the U.S., "Modernist" and "Traditionalist" at one time. Modernists are economically oriented, focusing on material success, and value the concrete evidence of the sense. They may belong to mainstream religious institutions, but their practical values are typically secular. The Traditionalists, on the other hand, emphasize "small town values", and desire a social order based on religious conservatism, male leadership, and traditional relationships. In recent years this binary distinction has given way at least partially to a third group, the Cultural Creatives.

Over the last forty years, Cultural Creatives have begun taking a global perspective on the world. They have also become concerned about issues like the suppression of women's voices across the culture, environmental destruction, violence, materialism/consumerism, and corporate power. Sixty percent of Cultural Creatives are women. They value relationships, self-actualization, authenticity, and spiritual development in their private lives, while in politics, they seek a third way beyond "left" or "right." While fifty percent of the current U.S. population is Modernist and twenty-five percent is Traditionalist, the remaining one-quarter of the population is Cultural Creative.

My experience interacting with coalition members suggests many shares a holistic concern for the well-being of patients. It would also appear that the marketing messages that accompany the alternative healthcare market are prevalent in local advertizing as well as the advertizing of national brands that are carried into the region via mass media.

Many of the holistic ideas that have been part of the rise of the Cultural Creative class and the market for alternative healthcare might be expected to find resonance with traditional Appalachian folk medicine to the degree that younger women in the region are still being exposed to folk healing traditions of the region as well as complimentary and alternative healthcare practices (Cavender, 1996, 2003; Cavender & Beck, 1995; Upchurch & Chyu, 2005).

Byrne (2007) argues that Appalachian senior citizens as well perceive certain significant barriers to health care access and these issues may be relevant to the increased use of complimentary and alternative forms of health care and folk remedies among the rural elderly in Appalachia. Access issues with out-of-town travel for care, the high cost of health care, “inaccurate diagnoses” of illnesses, too few doctors locating in the region, the unfortunate state of the roads, and the dearth of needed specialists are all issues in obtaining health care that may be relevant decisions to use alternative methods.

Typically, modern health promotions assume that people seek health information because they have made rational assessments of their self-interests and are making informed consumption decisions accordingly (Fishbein & Ajzen, 1975). Resource mobilization theories (McCarthy & Zald, 2006) in the sociological literature on social movements also draw upon this kind of rational choice theorizing, understanding collective participation as an effective means of reducing costs for collective participation and sharing needed resources, much in the same way coalitional politics distribute costs and benefits across networks of participating organizations and individuals. The problem for community members is how will they then secure accurate, up-to-date information and employ credentialed practitioners to meet their health needs. Ladies Day promotions to encourage cancer screening in local public health clinics follow this assumption, offering “incentives” for participating and condensing cancer prevention information into collections of “tips” that can be distributed quickly in the form of a flyer. The broader practice of utilizing the sales of cancer prevention-related stamps to promote cancer prevention fund-raising is the prototypical neoliberal participatory scheme in that the citizen-consumer can purchase a kind of participatory satisfaction from simply consuming the appropriate postage stamps (King, 2006).

Some campaigns motivate participants on a moral basis, connecting participatory

outcomes to a sense of outrage or injustice. This kind of motivational campaign was present in the early 2000s in eastern Kentucky. Other non-cancer-related promotions included the drive to form drug prevention coalitions during the height of the OxyContin scare in the early 2000s. Anti-Tobacco campaigns call on this kind of moral solidarity as well when they defend against second-hand smoke in public places. I would argue that the appeals to the sympathies of potential participants concerning family members lost to cancer in fundraising campaigns, like the appeals delivered during Relay for Life, also call for moral solidarity even as the promotion simultaneously supports an individualized notion of cancer prevention.

Thompson (2004) has developed a genealogy of the mythologies associated with the consumption of healthcare and alternative medicine characterizing the American healthcare marketplace. Cultural Creatives construct nature, technology, wellness, and illness through an Edenic myth, the myth of humanity's fall from grace (Thompson, 2004). This mythological construction attempts to mend a fundamental conflict redressed by natural health's marketplace mythology of holistic well-being concerns the relationship between nature and technology. Those that favor the use of alternative and natural healthcare methods and services see contemporary lifestyles and modern technologies as creating numerous unintended consequences, including stress, ecological degradation, and routine exposures to toxins. These unintended consequences make people unnaturally susceptible to illness, with modern medical science implicated as part of the problem rather than the solution to the ills of Modernity. This occurs primarily through the ways conventional medical science relies on technocratic organization structures and reliance on pharmaceutical and surgical interventions.

The Contrasts of Myths Underlying Alternative Healthcare Consumption

The Edenic myth of Christianity suggests holistic well-being as an ideal that concerns the relationship between nature and technology for consumers of alternative health remedies in the US, while a more techno-centric mindset is apparent in a larger portion of the population. Thompson (2004) also argues that trends in the healthcare market toward adoption of holistic healing approaches can be attributed to this group's willingness to experiment with new and alternative ways of living and thinking. For Schneirov and Geczik (1996; 1998), who have investigated social movement aspects of the alternative

health community, motivation to utilize alternative health practices contains an aesthetic core, a quest for harmony and balance that makes people not only seek knowledge of such practices, but also makes them available for participation in public life. These aesthetic, microcultural frames of reference are resonant with the appreciation for therapeutic self-improvement and moral triumph used to interpret consumption experiences by those involved in cancer prevention.

The primary narrative work needed to transfer the myth of Edenic unity to the natural health marketplace relies on the Romantic artistic tradition to derive its generic conventions (Thompson, 2004). Romanticism provides answers to the question of how humanity can regain its lost spiritual perfection. The myth of the Fall acts as an allegory about humanity's alienation from nature and is used to critique Modernity's emphasis on rationality, science, and technology, the "cursed apple" that had brought about the modern world's sense of alienation, disenchantment, and dehumanization. The Romantic legacy also relies on the "revenge-of-nature" trope, a cautionary maxim that warns us about how nature will eventually strike back at humanity for violating its sacred order.

Additionally, the use of the Edenic myth, according to Thompson (2004), also derives narrative conventions from the Gnostic mythos. This tradition refers to a legacy of heretical ideas that were kept alive in monastic orders and later embraced by many European cultural elites like Francis Bacon, Robert Boyle, Isaac Newton, and Rene' Descartes in the sixteenth and seventeenth centuries. Historically this tradition was embraced during a transition period between medieval monasticism and the Enlightenment. Mankind's fallen state could be ameliorated through social actions, allowing humanity to create its own earthly paradise. This pre-Enlightenment mindset viewed God as a master craftsman cable of shaping and perfecting Man with the help of reason and scientific knowledge.

In Table 1: Contrasting Myths Underlying Alternative Healthcare Consumption the Gnostic metaphors and their ideological agendas are on the left side and their Romantic counterparts are located on the right. Although these respective metaphors express historically countervailing views of nature and technology, Thompson (2004) suggest that Cultural Creatives typically do not experience them as necessarily contradictory. The mythological promises serve the infatuation of Cultural Creatives with

Table 1: Contrasting Myths Underlying Alternative Healthcare Consumption

Gnostic Metaphors	Romantic Metaphors
Divine Tool	Maternal Power
The Gnostic metaphor of technology-as-divine-tool conveys the mythic promise that the promoted brands of remedies have distilled, enhanced, and standardized the healing powers of nature, rendering them more efficient and effective.	Romantic metaphor of nature-as-maternal force and its corresponding mythic promise of regeneration.
<i>Ideological agenda 1 - Scientific testing, standardization, and laboratory development provide a rational license for consumers to believe in these promoted products.</i>	<i>Ideological agenda 1 – alternative remedies are portrayed as magic-in-a-bottle that enables individuals to access the regenerative powers of nature and unleash the full healing capabilities of their immune system.</i>
<i>Ideological agenda 2 - encourages a highly privatized, do-it-yourself approach to holistic self-care that is dependent on consuming a brandable remedy rather than a personal relationship to a practitioner.</i>	
Technological Liberation	Revenge-of-Nature
The mythic promise that follows from the Gnostic metaphor [of Technological Liberation] is boundless vitality.	Natural health media construe the most likely revenge-of-nature to be increased susceptibility to chronic illnesses and premature degeneration.
<i>Ideological agenda 1 - enjoins the need for ritual practices of purification to maintain the optimal functioning of the immune system.</i>	<i>Ideological agenda 1 – The immune system is under constant and increasing siege and must be strengthened accordingly.</i>
<i>Ideological agenda 2 - illness, poor health, and even run-of-the-mill fatigue are constructed as a personal failing.</i>	

integrative alternatives that circumvent cultural dualities. Alternative remedies promise their consumers “a miraculous blending of East and West, mysticism and science; traditional living and contemporary time-saving convenience; and, of course, nature and technology. These mythological promises also serve the ideological interests of firms marketing standardized herbal remedies.” My interest is both in the ways that the blending of metaphors resembles the kind of “brightsiding” (Ehrenreich, 2009) that is part of the positive thinking associated with mainstream cancer prevention, particularly that of the consumer-citizen, and how taken separately, there is something to the idea that each mythic system on its own supports that split in eastern Kentucky over surface

mining, with mining interests utilizing Gnostic metaphors of technological progress and many environmental groups holding to Romantic, traditionalist views of the Appalachian mountains as a holistic source of regenerative power and fears of surface mining leading in time to a revenge of nature. To summarize the metaphors associated with each mythic system, I will describe them as two different tensions, each with contrasting ideological agendas.

Divine Tool/Maternal Power

The Gnostic metaphor of technology-as-divine-tool conveys the mythic promise that the promoted brands of remedies have distilled, enhanced, and standardized the healing powers of nature, rendering them more efficient and effective. This metaphor is contrasted with a Romantic metaphor of nature-as-maternal force and its corresponding mythic promise of regeneration. Technology-as-divine-tool shows up in the Profile stories in the spiritual associations among ASC programs, social support, and recovery from cancer. It is accompanied by an ideological agenda that makes use of technocratic rhetoric and references to scientific testing, standardization, and laboratory development that serves to provide a rational license for the citizen-consumers to believe in these promoted products, as well as to justify making contributions that support the continued availability of the programs.

The Romantic metaphor of nature-as-maternal force and its corresponding mythic promise of regeneration encourages social support and community involvement, drawing on maternal imagery. I suggest that these metaphors are more likely to be part of environmentalist stories that emphasize the sacred connection many Appalachian families feel for the land. In stories like the 5-3-07 story, *Mountaintop mining focus of discussion*, in which the author recaps a community hearing about mountaintop removal as a moral issue affecting Harlan County, the Maternal aspect of the land is evident in the way the person in the story recollects his experience of the land as a child, but also, in the way that land is violated by mountaintop removal:

Just because the coal is here does not give these companies the right to come in here and destroy our land - destroy our homes...One of my fondest memories is going squirrel hunting and getting my first one in a hickory nut tree. That tree is no longer there, In fact, the whole ridge is gone. These coal companies come in here, disrupt our lives, rape our land, pollute our streams, and then they pull out, and we're left with nothing. Eastern Kentucky residents who have their homes

violently shaken from mountaintop removal, their wells polluted and their land razed and ravaged, firmly - and sometimes emotionally - told about their experiences.

I would argue that the ideological agenda here is the way that the experience of the land is held up as a kind of magical experience whereby individuals can access the regenerative powers of nature and unleash physical, emotional and spiritual healing. The Maternal land is robbed of its healing power through the trauma of rape and abandonment perpetrated by surface mining.

Technological Liberation/Revenge-of-Nature

The mythic promise that follows from the Gnostic metaphor of Technological Liberation is boundless vitality in which health products are portrayed as having energizing properties that empower individuals to do more and achieve more without succumbing to the limitations of fatigue or stress. In contrast, natural health media construe the most likely revenge-of-nature to be increased susceptibility to chronic illnesses and premature degeneration. The place of the Technological Liberation in mainstream cancer prevention culture is very evident in the continual urging of readers to become participants in volunteer activities, fun runs, and other lifestyle activities. For example, the story from 6-2-03, *White has made a career of helping others*, begins:

Helping people is more than a full-time occupation for Janet White. When she isn't running the Cawood High School Youth Services Center, the Harlan native is volunteering her time to fight cancer, clean up the community and repair homes.

The youth services position is based on a kind of social service technology that “combats everything from poverty to drug addiction”. The martial metaphor that accompanies the technology is evident here, understanding various social problems as “wars” which must be fought, with the problems, e. g., environmental pollution, and cancer, the decline of homes, poverty, and drug addiction, anthropomorphized as enemies to be defeated.

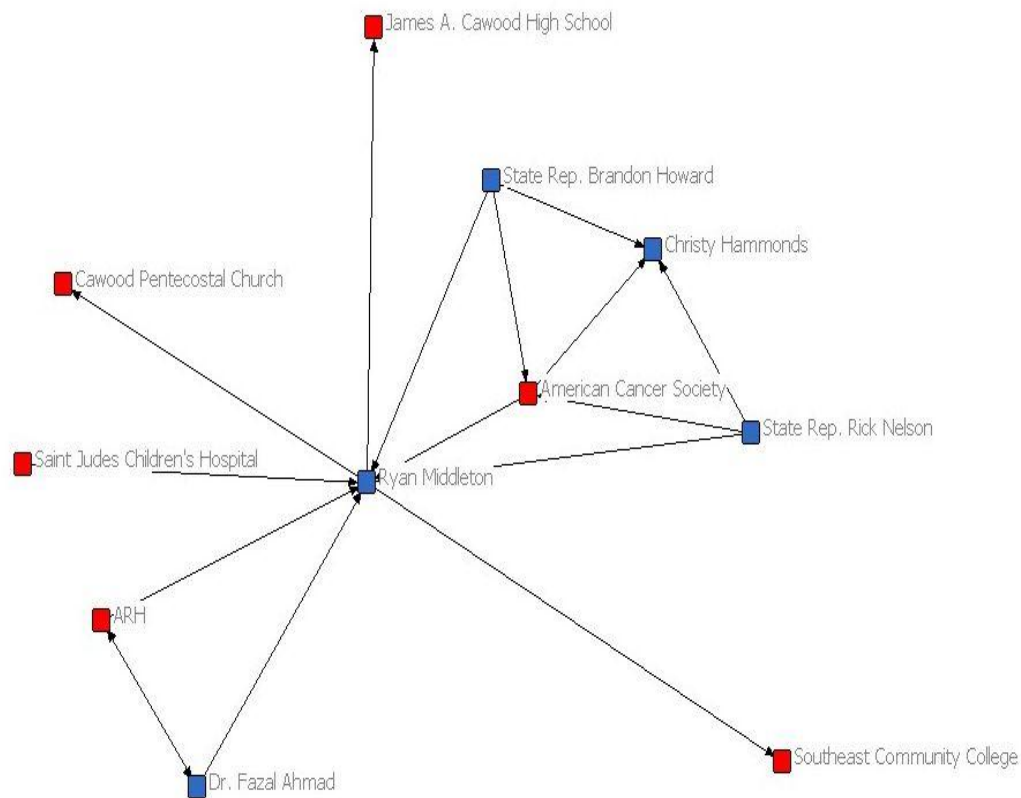
Many news stories construct the plot around a local hero and become stories about “especially remarkable people.” Such stories rely on a “twitch”, a literary device that that creates an experience of mild surprise in the reader by violating the reader’s expectations (Langer, 1990). This is accomplished by putting together two apparently contradictory

elements in the story line. The 5-17-03 story, *JACHS senior wins big game against cancer*, utilizes a sports metaphor to link the youthfulness of the story's central character, Ryan Middleton, to fitness lifestyle choices advocated by mainstream cancer prevention culture. The main contradiction in this story is the Profile character's youth (age 14) and the fact he contracts cancer, in this case, a rare form of bone cancer called osteosarcoma. The sports metaphor organizes the plotline, comparing the story of discovering the cancer through to its successful treatment to the progression of a game. The story celebrates the boy winning an ACS scholarship, with which the boy plans to attend the local community college after graduating high school.

Figure 2: Ryan Middleton Story as Two-Mode Network organizes the main character's story line as a two-mode ego network tying actors (blue squares) and organizations (red circles) together. The storyline begins in the lower left hand corner when the young man first sees a local physician, Dr. Ahmad, about pain in his leg. Moving counter-clockwise, the diagram represents his referral to a hospital for treatment, support he received from his church, and his eventual return to his former life as a high school student. He ends up winning a scholarship from the American Cancer Society for his courageous efforts in surviving bone cancer which he planned to use to attend Southeast Community and Technical College.

Figure 3: Ryan Middleton Story as a "Force Field" of Associative Meaning extends the previous network diagram into a "force field" of associative meaning (Langer, 1990) by inserting positive and negative characteristics attributed to the boy through the course of telling his story. As the legend to the diagram indicates, Ryan is represented as a light green square at the center of the diagram. Dark blue squares represent organizational contexts and the red and light blue circles represent the positive and negative events/characteristics Ryan exhibited in each of the contexts. From this diagram we can see that Ryan's identity is intimately tied to the storyline via successful movement through a number of stages of cancer treatment and the organizational contexts associated with them. The boy's transformation begins with his initial struggle with an "aggressive opponent" as a 14 year old high school student; it progresses until he matures as a young man looking forward to attending college and to seeing himself as "helping children in some capacity". The boy is understood as finding a calling, a place in

Figure 2: Ryan Middleton Story as Two-Mode Network

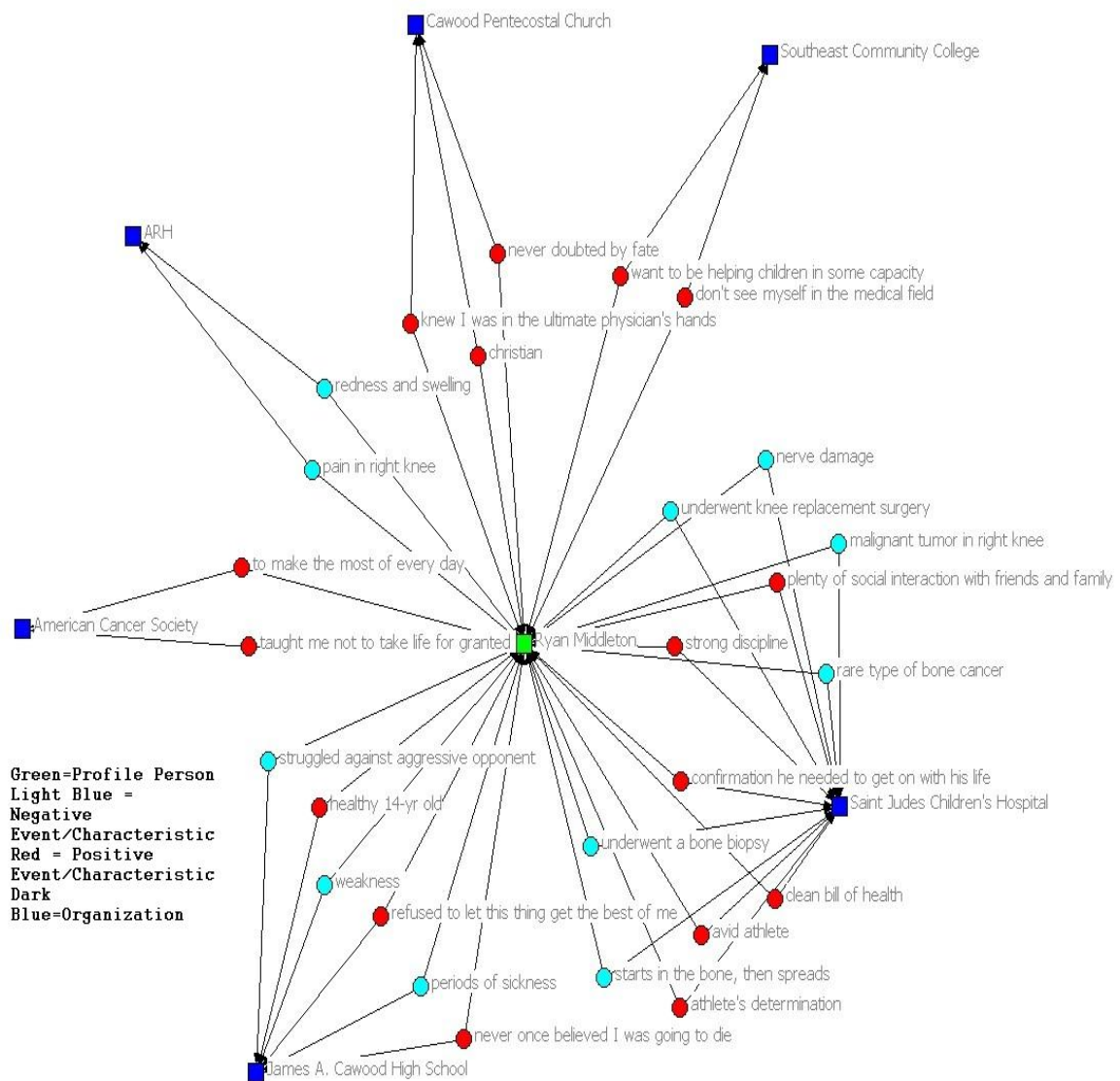


the service economy, through his cancer treatment experiences.

Ideologically, martial and sports metaphors that accompany the application of technology understand various social problems as “enemies” to be defeated. Once problems like environmental pollution, cancer, poverty, and drug addiction have been anthropomorphized and they can be “attacked” as personal failures within various policy “wars” as they have been at various times since the 1960s. To do otherwise has come to be understood as a personal failure.

As far as the contrasting Revenge-of-Nature trope, it is the lack of this metaphoric or mythic imagery in the Harlan Daily Enterprise stories that stood out to me as I read them. The work by Michael Hendryx (2011) on the public health impacts of mining on the health of Appalachian counties relies heavily on this kind of imagery. Hendryx (2011) discussed with me his concerns about the long-term effects of stress on coal mining

Figure 3: Ryan Middleton Story as a “Force Field” of Associative Meaning



communities, including exposures to noise, dust and dirt, water pollution, traffic dangers from coal trucks, etc. He also mentioned class-related health concerns that accompany negative health behaviors associated with working-class populations, including greater prevalence of alcohol and tobacco use, some types of negative eating behaviors and obesity, and the potential for work-related injury associated with doing mining labor. Hendryx associated many of these issues with weakened immune response, an ideological assumption that speaks to his background as a health psychologist. This ideological response has been part of alternative cancer discourses, but has gained

mainstream acceptance to some degree, mainly through the popularization of stress management techniques and other technologies of health psychology (Heinrich & Schag, 1985; Schneirov & Geczik, 1998). Ehrenreich (2009) has spoken out about non-critical acceptance of this position in cancer discourse because there has been little support for a psycho-emotional treatment response to cancer based on strengthening immune responses via psychotherapy. Still, this does not discount other possible immune response connections to illness related to the impacts of mining on regional communities.

Stories as “Metaphysical Terrain”

For Langer (1990), through the various encodings and narrative arrangements of story-types, a kind of “metaphysical terrain” is shaped by collections of news stories over time that depict the destabilization of normal causality as communities are described in terms of their various risks, then through the actions of characters (whether victims or especially remarkable people) who come to restore normalcy through tradition and ritual. Health promotion rituals, as I have repeatedly suggested throughout the project, offer “collectively fashioned, mutually recognized, and endlessly rehearsed predicaments of attempting to improve health in a world of apparently unhealthy enticements provide a template for our larger predicament” (Crawford, 2000, p. 221)”. For the most part, the stories in the Harlan Daily enterprise draw heavily from the metaphors and myths of the Gnostic tradition and understand progress in terms of scientific advancement in biomedicine. Technology is understood as a divine tool that promises to liberate and transform the sick from the limitations of the body. The Profile stories link the development of various organizationally-valued attributes to individual achievements and actions as they participate in the rituals of health promotion at the community level. These heroes serve as models for a new Appalachian identity suited to the changes arising as the mining industry declines and a new service economy evolves.

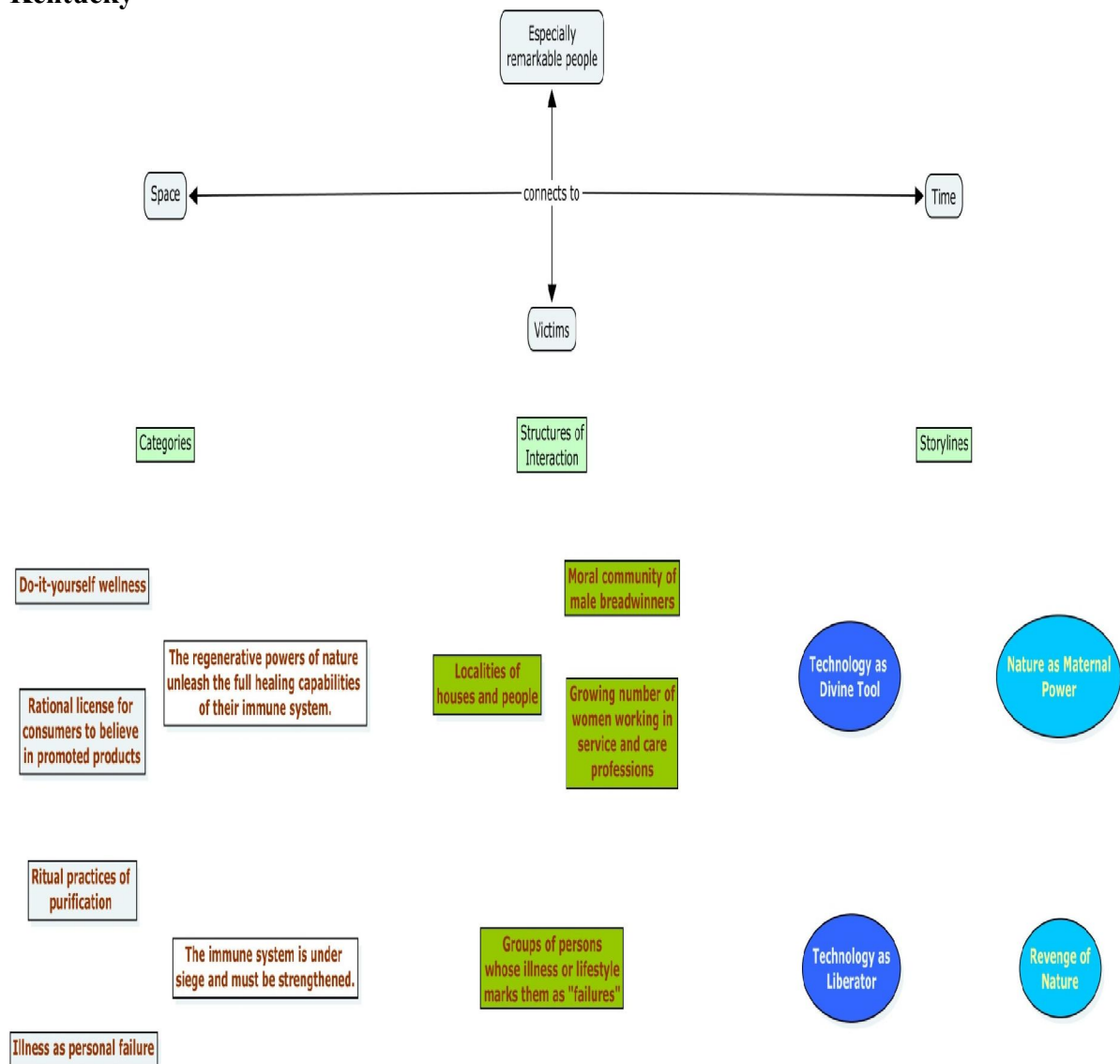
The usefulness of Thompson’s (2004) work is the way it articulates the two different mythological orders that appear to be contradictory. Thompson argues that Cultural Creatives have attempted to use the contradictions to formulate a new world view that moves beyond Traditional and Modernist world views. For my purposes, Thompson can be understood as clarifying several different mythological strains that color and texture how actors are positioned in narratives about health in the region. His work can thus be

used identify Modernist biases that predominate in most of the mainstream cancer prevention stories from the *Harlan Daily Enterprise*, while appreciating that other voices often speak from competing mythologies. Modernist notions appear to have some resemblance to the rational choice notions found in resource mobilization theories or the theory of reasoned behavior, while Traditionalist notions discussed by Thompson appear to have some similarity to the moral community idea. The Alternative Health worldview and the Green worldviews of Cultural Creatives appear occasionally, most often when health professional espouse a holistic view of their patients. Together, these mythic structures hail different readers as part of the larger effort to position subjects via preferred readings, but also serve as cues that some readers may use to develop negotiated and/or oppositional readings of texts. I also see Thompson's work as offering a source of connections between the aesthetic core of the alternative health movement and its colonization by health-related advertizing and marketing that Schneirov and Geczik (1996; 1998) speak of as well as the changes in labor sector composition that are affecting Appalachia discussed earlier in the paper. The result is a broad, complex and tangled knot of illocutionary forces that support a range of alliances and oppositions.

Figure 4: The Mythic Dimensions of Cancer Prevention Narratives in Eastern Kentucky maps Thompson's (2004) articulated mythic and ideological elements of healthcare advertizing in relationship to Törrönen's (2001a) ideas about subject positioning as described by categorization, positioning, and storylines and Langer's (1990) model of the mythological realm of tabloid news. The subject positions in texts are constructions which, on the one hand, evolve in a specific relation to the audience and to the existing subject positions in a particular context of interaction and which, on the other hand, obtain meaning by being attached situationally to categories and story lines. This model of subject positioning was discussed in chapter five.

Also in chapter five, I discussed use of the modal operator "can" in cancer prevention stories from the *Harlan Daily Enterprise*. Of the twenty-three times "can" appeared in the story cluster, twelve occurred in the subset of five Breast Cancer Awareness Month stories from 2003. Five of the twelve uses in the 2003 stories were part of "activity exchanges" and seven are part of "knowledge exchanges" (Fairclough, 2003). They include some emphasis on possibility and prediction, but mainly are used to promote a

Figure 4: The Mythic Dimensions of Cancer Prevention Narratives in Eastern Kentucky



perception of the ability to use situational resources to act, or to express the know-how that local service providers have acquired and internalized.

Organizationally, competition for attention from media based on perceived expertise is won in large part on expectations that the control of such resources is in the hands of particular organizations and not others. Claims of success are warranted in large part through control of the definitions of what resources are needed and demonstrations that, indeed, an organization has the means to use those resources. Local service providers and ACS volunteers are, along with cancer survivors, valorized and shown to be committed to

a particular truth about cancer as it fits with the broader Early Detection and Screening Advocacy culture of action. This emphasis on the narrow truth of the Early Detection and Screening Advocacy culture of action makes alternative voices like those of people of color or from low income backgrounds practically impossible to hear above a promotional culture (Wernick, 1992) that continues to aestheticize the experience of women in relation to a version of high society, traditional femininity (Sulik, 2011) that is foreign to many women in eastern Kentucky.

The profile stories I extracted from the Harlan Daily Enterprise (HDE) appear in the context of the broader array of stories discussed in the previous chapter as well as within the context of the pervasive fundraising and advertizing of healthcare services as the commodities of the healthcare market. In the profile stories there is an inter-weaving of narratives of individual heroics and the narratives of the campaign that recontextualized elements of the survivor story so that they serve the logic of the promotion. To stay on script, the narratives also rarely, if ever, mention the toxic consequences of industrial production, with its concomitant externalization of costs that include industrial pollution, the continuing presence of toxic ingredients in commodity production, environmental degradation, and reduced health insurance and wages for workers in proximity to the heroic narrative forms (Ehrenreich, 2010). They rarely mention alternative story lines about the struggles of marginalized individuals against health care profit taking and the exclusions such practices create.

In the regional context of Appalachia, the stories make only minimal reference to poverty, and no direct connection to the realities of prescription medication abuse that plagues the very generation of women eligible for cancer screening services, even though concerns about addiction are high on the list of health concerns among women in the region (Schoenberg, Hatcher & Dignan, 2008). Poverty and addiction, along with environmental injustice, are naturally occurring themes associated with the “health disparities” experienced in the region, yet they are absent from the mainstream discussion of cancer prevention. Instead of including the volatile, politically difficult themes that make cancer prevention an ill-defined and somewhat intractable issue in the region, the genres deployed in local media stories have continually taken a tabloid or promotional form that either focuses on the actions of celebrities and other elites or attempts to elevate

everyday people, at least temporarily, into a celebrity-like status through the use of heroic storytelling features in the narratives of the news stories. This makes examining profile stories in local context important for developing cultural and environmental competences about how cancer and its prevention and treatment are understood in a given community (Hendryx & Ahern, 2008) that would deepen our understanding of the appeal and politics of health promotion narratives. Profile stories represent a series of particularized class and gendered interests being represented as universal. They attempt to guide readers along a path aligned with continued techno-economic development and they are generic examples of a particularized chain of equivalences defining an institutionally accepted regional consciousness organized within a universalized horizon of meaning that also makes claims about the identity of the Appalachian region.

Raw-Cooked-Rotten

The various identities of Appalachians can be understood as objects in consciousness through which people make distinctions between themselves and between cultural and natural objects. The relationship between culture and nature can be framed as a progressive movement such as those found in survivor stories, whereby people move from the “natural”, healthy state of their daily lives, through the enculturation of treatment, and back again to nature and health. Coupling such progressive narratives with tales of community-based responses to health problems amplifies their progressive character, creating a sense of solidarity that tacitly implies that communities reject obsolescent, old fashion healthways. Regressive movement follows a path which is shaped by rejection of treatment options or refusal to make progressive changes. Rejecting treatment leads eventually to a state of decay and death. Historic associations to bootlegging, moon shining, and tobacco farming amplify the now obsolete reliance on these forms of production in light of the growing consumer economy. These are stories about those who succumb to illness, but also stories about those that succumb to addiction or other negative health behaviors. Such tales are the stories about “throwaway” populations as discussed by Watkins (1993) and by Jarosz & Lawson (2002).

Culture turns natural objects into cultural objects by naming them. It also has the capacity to reflect the borderline between nature and culture through what can be called

second-order representations (Levi-Strauss, 1975). These secondary meanings supplement meaning, often through mythic stories and tales. As stories about heroic subjects, wondrous objects and magical events, myths represent the borderline between what is cultural and social, and what is outside culture, asocial and not meaningful. Levi-Strauss (1975) analyzed this second-order, reflexive capacity in cultural storytelling using Brazilian myths about food through application of the "culinary triangle".

In his work with media stories about alcohol addiction, Sulkenen (2002) fit this kind of progressive/regressive dynamic into Levi-Strauss's culinary triangle.

Myths related to food tell of the origins of foodstuffs, about different ways of preparing them and about the risks and dangers involved in violating taboos that regulate eating. They classify edibles as raw elements of nature or as processed food, part of culture. Some edibles may become over-processed and turn to rotten material or excrements. This is true of all cultural food systems, even in our modern societies. But what is classified as "raw", "processed" or "rotten" varies between different societies. Food images represent the borderline between culture and nature. Myths are stories and therefore they describe transformations. What is one thing at the beginning becomes something else at the end. Strauss distinguished two different types of transformation: those ascending from the raw, unprepared state of nature to foods that are elements of culture, for example by cooking; and those descending or regressing from food to rotten material or to excrement. The first is a positive transformation; the second negative, representing destruction and decay towards death, and therefore it is abhorrent and dreadful (Sulkenen, 2001b, p. 1310).

The saturation of modern post-industrial cultures by science and technology has exacerbated ambiguities that accompany the sorting of natural from cultural objects (Sulkenen, 2002). Instabilities in meaning, such as that between service labor and industrial labor, with its accompanying feminization of employment and masculinization of consumption (Watkins, 1993; Jarosz & Lawson, 2002), are social spaces where multiple interests and discourses intersect. Through reliance on the claims of technological excellence and biomedical expertise, as well as the incorporation of the notions of "community-based participation", "class-as-lifestyle", and "health disparity", different knowledges must be "translated" across social boundaries and these translations are often incomplete or partial. The mainstream cancer prevention discourse attempts to claim a kind of completeness and inclusivity that is actually out of its reach. Transgressive health behaviors like overeating, smoking, drug use "lie in the gray area

between the usual dualisms of nature and culture, where the social is what is understood and ordered and the natural is what is unsaid and nameless (Sulkenen, 2002, p. 266)". From the perspective of "Pink Ribbon" culture, negative health behaviors are associated with culture and socialization, which fits neatly into the "class-as-lifestyle" imagery by associating the behaviors with an obsolete past (Watkins, 1993). This view has gradually replaced the environmental pollution emphasis of the 1960s and 1970s, which suspected cancer was the "natural" consequence of exposures to industrial pollutants that are independent of cultural factors. Though it may not have been the conscious intention of health educators initially, it has been a matter of concern to many researchers that the emphasis on lifestyle and individual behavioral change in cancer prevention discourses resonate with the conservative political ideologies that have entered the public consciousness since the 1980s. Such an ideological shift has possibly lead to an overestimate of the important of health behaviors and lifestyle at the expense of "passive" interventions like industrial regulation that affect levels of carcinogens and other pollutants entering the ecosphere (Ruzek, 1997).

Adaptation to institutional frameworks is one of many storylines that can be read in health literature on Appalachia generally, and eastern Kentucky particularly. Stories of adaptation related to cancer prevention are typically fit within the transformational plot line that characterizes a lot of health and fitness literature. Not only does one successfully overcome the disease, but they are transformed as a person in the process, somehow becoming more than they were before the illness tested them. Stories about transformations from illness to health are depicting a desirable progression that restores the social order as well as the physical body.

Yet other storylines circulate within this system. There are economic development stories about "timeless" Appalachia which depict the population of the region as founding pioneer stock, descendents of Daniel Boone and inheritors of the Cherokee lands of the region. These storylines have been part of the discourse of uplift that has framed Appalachian identity tales since the late 1800s (Billings, Norman, & Ledford, 2000). From this perspective, the "hillbilly" is a pre-modern throwback, a primitive still rough, unhewn, and close to nature, deserving of help in being acculturated into the modern world through education and other benefits of modern industrial society. But by the time

the development publication, *Change in Rural Appalachia: Implications for Action Programs* (Photiadis & Schwarzweller, 1970), was published, social scientists were suggesting that old, outmoded ways of life that once served rural Appalachians well were no longer viable in the fast-paced modern world (Lewis & Billings, 1997). Traditional ways were understood to be breaking down and the values of mass consumer culture and the middle class life styles of mainstream America were being embraced and emulated throughout the mountains. As the transition continued into the last quarter of the 20th century, the most geographically remote portions of Appalachia were still believed to resemble the pre-modern pioneer culture even as the duress of rapid change supposedly pushed some Appalachians to retreat into a culture of poverty. This bifurcation of the regional culture into those who accept change and those who resist it has continued into the 21st century.

One strain of resistance story has included stories of worker and community-based endeavors, which offer examples of the poor, the working-class, and the middle-class men and women of the region facing challenges with resourcefulness and determination of the "grass-roots" in spite of very difficult odds (Anglin, 2002). These stories are stories of change from the bottom up that contrast with the industrial/technological stories of economic development. "Such instances of political praxis likewise supplant ideas about a timeless, singular "Appalachia" with multiple representations of regional culture that are informed by particular histories, social locations, and economic contexts and are strategically positioned against dominant constructions of a place and a people in crisis (p. 565)". In some ways, the recent stories which identify the region's economic identity exclusively with mining and are used by the mining industry to fight regulation of mountaintop removal attempt to co-opt this tradition of organizing (Bell & York, 2011). By stirring up fear and anger about employment security, the coal industry has been able to mobilize workers and their families against policies that threaten their bottom line. They also make claims to salvage mining from being located in the obsolete past of the passing industrial economy, portraying it as still economically relevant even in the face of the coming transition to service labor.

Among the more recent dominant constructions of eastern Kentucky, there are also stories of transgression that lead into failure, of death and decay. These are regressive

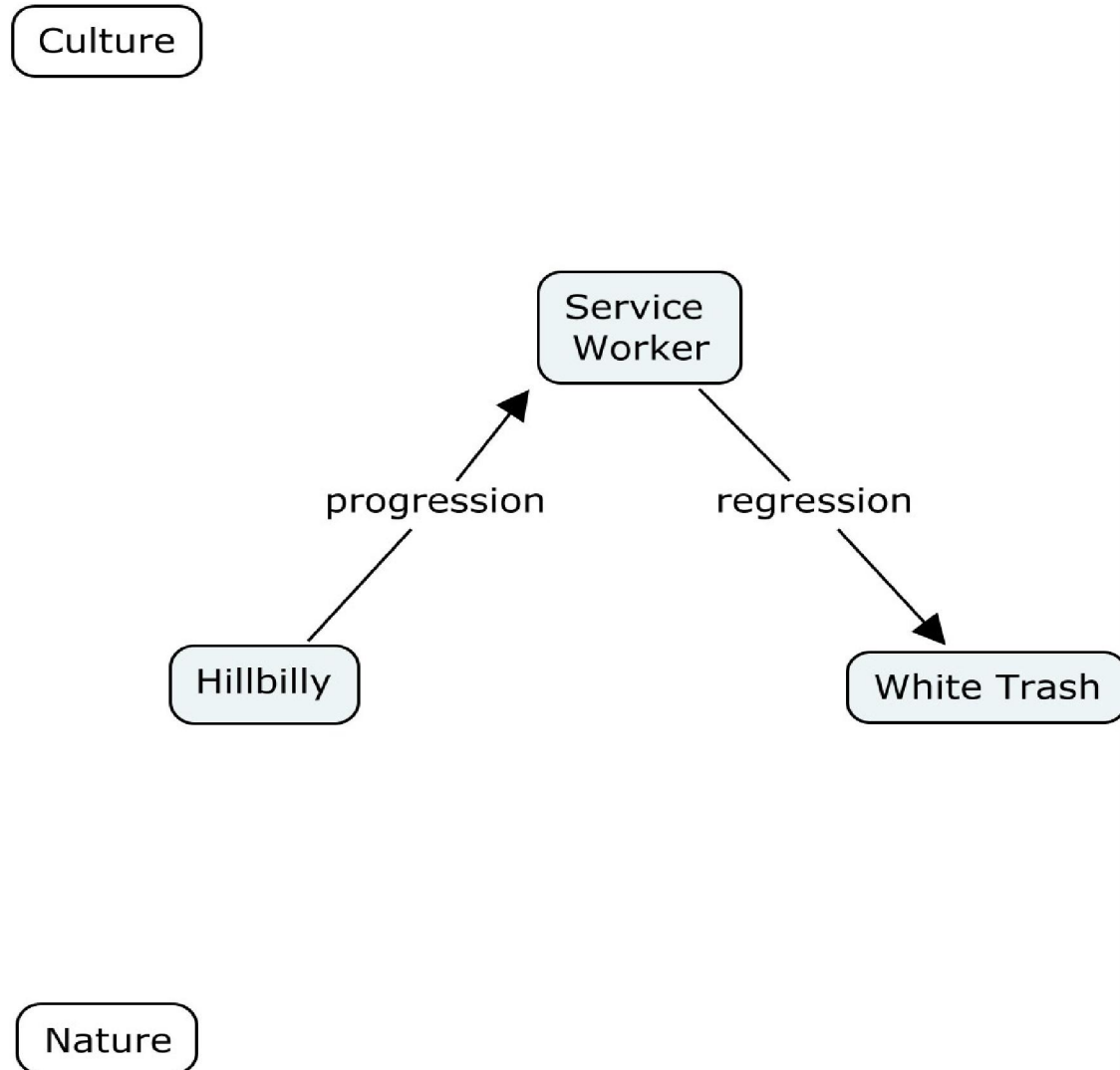
stories that utilize “class-as-lifestyle” to depict negative health behaviors as the outcomes of culture and socialization. They include depictions of drug-addled pain medication addicts; lazy welfare cheats; obese, toothless single moms unable to raise healthy, slim children; and wheezing, cigarette-toking ex-miners, with crippled backs and an oxygen tank on wheels. This story set has co-opted parts of the grassroots storyline as well, using coalitional politics to build partnerships with community organizations to manage the “complex, extensive, and intermediated networks of consequences” that arise from the lifestyle choices of community members.

Figure 5: Appalachian Identities: Raw, Cooked, and Rotten fits the broad categories of “hillbilly”, “service worker”, and “white trash” identities to Levi-Strauss’s framework. The motor of transition along either the progressive or regressive pathway are “technoideological codings” (Watkins, 1993) that mark patterns of productive or consumptive activity as “innovative” or “obsolete”. The rituals and traditions that restore normal causality to the community have been legitimated through various processes of expert reflexivity as culturally valid within the “class-as-lifestyle” discourse, while those that have not survived this reflective process have been marked as part of obsolete traditions. The hillbilly can be transformed culturally to find a place in the new service economy by adopting current innovations in the “projects of self” that would allow them to become flexible workers in the new economic regime. To do otherwise is to slip into obsolescence and be marked as part of the throwaway populations of surplus labor that survive on the fringe of the economy through under-employment, activity in the informal economy, or through illegal activities like drug dealing or marijuana cultivation.

In Closing

The two discourses identified by Mary Dixon-Woods (2001) in the literature on how doctors communicate medical information to patients through the use of leaflets and pamphlets indicate that the first of these discourses reflects traditional biomedical concerns (see Chapter Five). Typically, this literature invokes a mechanistic model of communication in which patients are characterized as passive recipients, open to manipulation in the interests of a biomedical agenda. I would argue typically that this literature is typically also concerned with the accuracy of health information rather than its emotional impact or its relational connectedness (Seale, 2002). Also, I would argue

Figure 5: Appalachian Identities: Raw, Cooked, and Rotten



that it is likely most resonant with the Gnostic metaphors and ideological agendas discussed above (Thompson, 2004). The second discourse draws on a political agenda of patient empowerment, choice of outcomes of interest, concern with the use of leaflets as a means of democratization, and orientation towards patients. In practice, this discourse has become fragmented, in some cases reflecting Romantic notions about a return to nature, possibly through the inclusion of spiritual practices from an ancient past or from traditional religious systems from other cultures. In some cases it incorporates the languages and discourses of the Cultural Creatives that occupy various social niches in late modernity. Additionally, one can add a turn towards consumerism in healthcare in

which participation is assumed to be undertaken by citizen-consumers exercising “freedom” in both the economic and political sense, and through their healthcare choices add a neoliberal twist to community participation.

In the Appalachian context, all of these notions of participation circulate, though I have argued that the neoliberal version is the one driving cancer prevention activities through coalitional politics and mediatized health promotion. Dixon-Woods (2001) suggests that the two discourses, though distinct, are not entirely discrete, and may begin to draw closer as they begin to draw on a wider set of resources, including sociological research and theory, to develop a rigorous theoretically grounded approach to patient information leaflets. Both literatures appear to be based in the historic framing of the doctor-patient dyad, and I would argue that both are subject to the same error of reducing the medical encounter as a dyadic one rather than some variation on configurations of triadic and larger groupings that tie parties together or distance them in the encounter. The error has the overall effect of supporting the hyper-individualization of medical concerns while preserving the privileged position of physicians as gatekeepers of health-related expertise in place. It also preserves the exclusivity of this expertise as a valued commodity that is one of many potential benefits of biomedical services in a growing economy. Expanding healthcare services as part of regional economic development also creates educational and employment opportunities for communities.

Early development economics, such as the conference that produced *Change in Rural Appalachia: Implications for Action Programs* (Photiadis & Schwarzweller, 1970), expected an interventionist state to correct market failures in most economic sectors and thus ensure economic efficiency, growth, and social development. According to Stokke and Mohan (2000), the neoliberal counter-revolution in development theory shifted how the state is seen in economic development, now viewing state regulation as a barrier to development rather than a force that drives the development process. During the "Reagan Revolution" of the 1980s, neoliberalism offered a strong critique of the welfare state and promoted market liberalism as the most efficient mechanism for delivering economic and social development within an ever globalizing market system. Recently, neoliberal development strategy has shifted away from a singular emphasis on market deregulation and has begun to emphasize institutional reform and social development. Civil society

has become the arena in which a host of development objectives are to be achieved, with civil society thought of as an arena that can exert organized pressure on an unresponsive state in support of democratic stability and good governance. Civil society institutions can also be shaped for use as vehicles for participation in development programs through the empowerment of target groups of poor people. The discourse incorporates notions like "stakeholders" and "local governance" to describe this effort, but as described in chapters two, four, and five, what we see instead is that coalitional politics often overwhelm the voices of marginalized persons and groups when organizational entities with the greatest access to needed resources are best able to compete for public attention through promotional activities and exercise their status as "expert" sources for local media.

Much of the analysis of the previous five chapters has been focused on exploring the dialogical and intertextual aspects of regional identities that actually produce a range of collective actions around healthcare and cancer prevention. I explained in earlier chapters that what might once have been an effect of social movement activity and collective action on regional public health has been in the process of institutionalizing around core infrastructures that were put in place in the early 1990s. At another level I have been questioning all claims to authority and truth based on neoliberal concepts around freedom and the ways that participation in marketized healthcare promotions justify dignity and greatness through the construction of the citizen-consumer and the cancer survivor (Boltanski & Thévenot, 2006; Sulkenen, 2011). By doing so, I have questioned universalist, technoideological, and male-biased claims to truth that circulate in cancer prevention discourse in order to reveal their inherently power-laden and silencing effects. Some of the most powerful silencing in eastern Kentucky has occurred in relation to the impact of a coal mining on the public health of coal-producing counties.

The fragmentation in community views that I have discussed in this and previous chapters is a the result of a failure on the part of the cancer coalitions and public health officials in eastern Kentucky to take a stand against, among other "risks", the health damaging impacts of coal mining on the health of coal communities. This is a simplistic claim, but one that is beginning to be made in anti-mountaintop removal circles. And even as some researchers have been confronting the health consequences of mountaintop

removal, they have also been confronting the hold Big Coal has on state politics. This second line of argument has been threaded through concerns about surface mining in eastern Kentucky at least since the days of the Save the Land and People movement in the 1960s. These voices have developed sophisticated arguments about the impact of corporate money on regulatory policy development in relation to the coal industry.

Similar critiques have emerged in the healthcare sector, with the critique of privatization and corporatization related to neoliberalism starting as early as the 1980s as the Reagan Revolution started touting smaller government and greater support from the private sector for philanthropic programs (Starr, 1999; Pollitt, 1992; Evans, 1997; Navarro, 1993; King, 2006). What I have tried to do throughout this project is find elements of the everyday discourses and practices that now overlap between the two sectors so that one can recognize a systematic regime of practices at work that limit the discourse on a general problem of economic development within the Appalachian region that in turn stifles discussions about what is possible for the region. My assumption throughout this work has been that participatory practices like cancer prevention coalition activity, because they are implemented within an extremely narrow mission, are doomed to perpetuate local health care inequities because they do not sufficiently move outside mainstream practice models to confront deeper sources of disparity. Grounded in regional public health institutional hierarchies, the coalitions tend to act more as an infrastructure for making difficult decisions of the distribution of limited resources for cancer prevention activities than as a vehicle for democratic discussion.

By importing mainstream promotional forms into the civil society, local media *refeudalizes* (Habermas, 1962) the public sphere and implants a de-differentiating, “aestheticizing” impulse (Harvey, 1990; Lash, 1990; Chouliaraki, 2000; Fairclough, 2003) into local health-related discourses. Complimentary themes of community participation and personal responsibility are distributed across homologous organizations in the region like Personal Responsibility in a Desirable Environment (PRIDE), which focuses on the environmental cleanup of solid waste and other environmental problems and Operation Unite, which is focused on addiction. These groups have all been started after periods of media agenda-setting by state and federal governmental actors to create a sense of urgency about their respective problems, with each coalition having some small

amount of funds available to help them get started. There is also state level support by regional coordinators who act as organizers that help the groups get up and running. Public attendance may be high initially while emotions are aroused, but begin to wane over time. Local community members find little outlet to express their concerns because the missions of such coalitions are typically restricted and narrowly channeled. The coalitions become infrastructures for inter-organizational communication that control the flow of shared (but limited) local resources and engage the community as potential consumers rather than acting as a stimulus for broadened civic involvement.

My goal in this project has not been to offer a new set of recommendations for solving regional healthcare concerns in central Appalachia, but to offer a critique that might stimulate discussion among different sets of actors in the region working on what appear to be at times intractable issues of social inequality and community distress, ill health, and community decline. By widening the scope of examination to include a possible set of connections between historic problems in eastern Kentucky with unemployment and poverty, public health concerns like high cancer burdens and addiction, and environmental degradation, I hope to promote questioning of neoliberal impulses of regional economic development and public health policies. I also hope to encourage revisiting the social democratic spirit of regional environmental activism by the public health community. It is my hope shifting our priorities would reinvigorate community participation in public health policy-making and allow ever more marginalized voices to be included at the table.

Chapter Nine: Closing Thoughts

Health promotion, including the conflicted and inconsistent adoption or rejection of medical prescriptions and proscriptions, can be understood as a ritual which attends to ‘matter out of place’: a contradiction in structure – at once material and symbolic – which is the source of a conflict in experience for contemporary Americans. Advanced capitalist societies are beset by a contradiction between production and consumption, which in its cultural form defines the parameters for crucial conflicts of individual behavior, morality and identity. Health promotion is meaningfully situated on an ‘axis of continuity’ with the cultural contradictions of capitalism – an axis in that those contradictions and their experiential conflicts “meet and converge” in health promotion and continuity because the two domains of experience have ‘family resemblances and connections’. I am proposing that the collectively fashioned, mutually recognized, and endlessly rehearsed predicaments of attempting to improve health in a world of apparently unhealthy enticements provide a template for our larger predicament (Crawford, 2000, p. 221).

The illocutionary forces constitute the knots in the network of communicative sociation: the illocutionary lexicon is, as it were, the sectional plane in which the language and the institutional order of society interpenetrate. This societal infrastructure of language is itself in flux; it varies in dependence on institutions and forms of life. But these variations also embody an innovative mastery of unforeseen situations (Habermas, 1987, p. 321).

What I Set Out to Do

When I began this project, I was meditating a lot on the two quotes above. It made sense to me that in order for the health promotions of preventive medicine to work, healthy behavioral choices needed to be learned, practiced, and internalized to the point that the implementation of the behaviors becomes automatic, implicit, and backgrounded. The behaviors would need to be ritualized and rehearsed in relation to particular social contexts. In a word, they had to become implicit in the lifeworld a community. Unhealthy behaviors are often described in the popular literature on prevention and wellness as involving some kind of compulsive/impulsive behavior, often labeled as “addiction”, with the prototypical objects of the addiction –alcohol, tobacco, unhealthy food choices - representing exactly the kinds of “unhealthy enticements” Crawford is talking about in the quote above. This labeling of consumption marks a somewhat arbitrary boundary between “normal”, “healthy”, consumption, and “abnormal”, “unhealthy” consumption in a world where what are the appropriate limits for consumption are becoming increasingly

obscure.

In the systems of lifestyle intervention in the prevention model, “healthy” behavioral options are to be substituted for “addictive” responses in the course of one’s daily routines. The selection of “healthy” behaviors must meet the normative standards at play in the particular context. It appeared to me that the way these behaviors are “collectively fashioned” must involve some kind of consensus building process that not only selects some behavioral options as appropriate, “healthy,” or moral, but also defines others as inappropriate, “unhealthy”, or immoral. Yet such consensus in the lifeworld is increasingly absent as medical and other health experts become the arbiters of such definitions. Efforts to “de-medicalize” health-related decisions, i. e., to reject the application of overt medical authority, have served to reconfigure medical authority as part of a larger sphere of professional services that have, ironically, enhanced, rather than decreased, medical authority (Maguire, 2008). Health promotion and other allied health services have joined a range of health and fitness industries in reformulating their authority in making decisions in the face of the dilemmas to which Crawford (2000) addresses himself.

Reading the Crawford quote in light of Habermas had me thinking about the ways that ritual repetition supports the stabilization of networks of practices as relatively permanent, long-term social structures, that is, as “knots of sociation.” These knots include both implicit and explicit elements, with past struggles to reach a consensus on the appropriateness, healthfulness, and morality of behaviors having been forgotten (or possibly reified and spoken of only euphemistically). Habermas recognized that these past struggles are included in the ways meanings are continually in “flux.” Consensus building, grounded in the issues of the lifeworld, can have a “therapeutic” impact on a community if reason emerges as the result of the triumph of the best argument. On the other hand, systematically distorted communication only buffers social boundaries against overt conflict over “sensitive issues” by premature closures in civic dialogue. Money and power become means to colonize deliberations and silence potential conflict in the name of efficiency and legalistic notions of accountability. Reliance on expert knowledge can become a means to premature closure to the degree it silences reasonable arguments from being aired. This issue became central to my questioning of claims that

cancer prevention coalitions in eastern Kentucky are “grassroots” organizations.

Summarizing the Chapters

Chapter one was offered as an attempt to use the Theory of Communicative Action (Habermas, 1983; 1987) to conceptualize neoliberal economic policy as a colonizing force undermining efforts to develop community-based cancer prevention coalitions in eastern Kentucky. The use of participatory practices and the language of empowerment threatens to be little more than “buzzwords” in this project since “participation” has come to have different meanings depending on whether or not participation and empowerment are defined from a “top down” or “bottom up” position (Mohan & Stokke, 2000). Neoliberal participation is a "top-down" strategy for institutional reform. State agencies and collaborating non-governmental organizations encourage community engagement in efforts to make institutions more efficient. Target groups are identified and included in the development process. Neoliberal participatory strategies define participation and empowerment within a harmony model of power, such that power resides with individual members of a community and can increase with the successful pursuit of individual and collective goals. The implication is that empowering the powerless can be achieved within the existing social order and without any significant negative effects upon the power of the powerful.

Post-Marxist participatory strategies, as Mohan and Stokke (2000) label them, are different from the neoliberal view in that a more radical notion of empowerment is conceptualized as a ‘bottom-up’ social mobilization in society. Mobilization challenges hegemonic interests within the state, and society. Marginalized populations are encouraged to achieve conscientisation and collective identity formation in response to economic and political marginalization. Power, from this perspective, is conceptualized as relational and recognizes the potential for conflict. The empowerment of marginalized groups requires structural transformations of economic and political relations towards a radically democratized society. The participatory, “patient empowerment” discourse in health promotion often sounds like the Post-Marxist position, but in practice, many programs actually are structured in line with neoliberal dogma, designed to maintain harmony locally and to work within existing power relations.

In chapters two and three I demonstrated that coalition tie patterns are shaped by

preferential attachments that follow from organizational hierarchies and the flow of organizational resources. I argued that the use of county public health centers and professional coordinators colonize social ties and shift the intersubjective basis of networks away from the lifeworld of the eastern Kentucky counties to a professional/academic social world organized by expert institutional discourses about cancer prevention. In chapter four, distance was shown to affect the rate of referrals for colorectal screening in a network of health providers in eastern Kentucky counties. The tie pattern in the referral network was argued to be a proxy for local common sense understandings about how far patients would be willing to travel to be screened.

In chapters five and six, how ties among actors, organizations, and story themes about cancer prevention in a local newspaper were represented were shown to be the result of how organizational actors compete for media attention concerning cancer prevention policy and practices. The tie patterns were analyzed in relation to features of the linguistic Register that represents power and solidarity as part of the social context of the region. To tease apart features of the Register, ideas about the dialogicality and intertextuality of the texts were used to recognize how news stories reflect choices made by newspaper among voices in the community that are competing to define issues of concern including cancer prevention, the consequences of coal mining, and the relationship between the two that are part of the public health of Harlan County, Kentucky.

Chapter seven expanded the interpretation of cancer prevention texts as they appear in the Appalachian context by exploring “class-as-lifestyle” as a mythological theme that pervades the cancer prevention literature. This mythology intertwines modernist ideologies with oppositional themes drawn from Romanticist and Gnostic traditions, making it possible to provide narrative adaptations to cancer prevention stories so that they both support biomedical intervention as treatment of choice and promise emotional and spiritual transformation. This mythology also accounts for the “unredeemable” among the regional population, the “throwaways”, who succumb to cancer and other lifestyle failures because they fail to adapt themselves to the disciplines necessary to maintain a status as middle class consumers.

Experts, Cancer Prevention and Knowledge Gaps

Feminist scholars speak of “epistemologies of ignorance” (Tuana, 2006; Sullivan &

Tuana, 2007) whereby selective problem-solving by experts shapes the nature of what is known or not known about particular domains of scientific knowledge, thus also shaping what emerges as knowledge gaps. I have been suggesting throughout this project that one aspect of the selection of knowledge about cancer as packaged and presented in cancer prevention promotions is that it is limited to challenges to citizen-consumers to manage their individual contributions to the cancer burden of the region through lifestyle change while ignoring questions about the environmental consequences of relying solely on a few industrial and service sectors to provide employment to the region. Hence, the “gap” that has developed in community knowledge about the relationships among class, lifestyle, environmental degradation, and health disparities is doubly structured by the internal dynamics of the healthcare industry that seeks to manage the risks posed by a costly group of risky patients and by the external dynamics of regional economic development that have become “addicted” to coal-based employment.

This knowledge gap, described above primarily through its anchors in the realm of production, is tethered as well in the continual cultivation of the consumption of health and fitness products and services by the totemic aspects of healthcare consumption in promotional culture:

If the meaning of the brand-name can extend outward towards a myth of capitalist production, it can also extend inward towards the psyche of the consumer. In the mirror of the ad, you, the reader, are [the mythic subject]. The object bearing this name is your own essence, and by consuming it you would be indicating your membership in the communion of all those who share it with you. The narcissistic binding of the ego to product, as an act of individual and collective self-celebration, converts consumption into a sacrificial rite. Given that it is the self that is perpetually on the altar, such advertising gives a bizarre twist to the Hobbesian vision of Man as being of infinite appetite. (Wernick, 1992, p. 34).

With the advent of the transition of the national and regional economies towards a service economy, the boundary between production and consumption, never clear cut in the first place, has further blurred. Appearance and performance operate as tools by which promotional subjects influence others and accomplish belonging (Maguire, 2008). The citizen-consumer is a promotional subject that “votes with his pocketbook” in order to exert influence over others and purchase the positive moral feelings of participation in “social change” campaigns. Market segmentation and the perpetual churning of consumer

groups to shape evolving tastes has shifted attention away from historic collective reflexivity to enthrone individual consumptive preferences as the new “freedom”.

So What? Is There a Recommendation Here?

So are there recommendations that can be made in the light of the analysis presented in this study? The project is worked out at two separate, but related levels – that of the coalition networks and the promotional activities in which they engage, and the ways prevention activities and the organizations that take part in them are presented in local print media. I want to focus first on the level of print media presentation.

The media level of analysis pointed to a general problem of how moneyed-interests maintain a focus on individualistic, consumerist notions of “participation.” As such, community participation is reduced to the consumption of healthcare services and “pink” fitness and beauty products, while collective action is channeled to fund-raising events primarily directed towards keeping several national charities operating.

This kind of media practice forces local organizations to compete for media attention in order to get their voices heard, assuring those with greater resources available for managing how they are presented to the community will be best able to shape how issues are framed. In the chapters on Harlan County print media stories, the American Cancer Society and Appalachian Regional Healthcare captured most of the media space about cancer issues while the local cancer coalition was nearly invisible to cancer issues. The public health clinic in Harlan, the agency where the local cancer coalition has been established, was able to share a story about services for the uninsured. The Appalachian Regional Hospital in Harlan also shared a story favoring single-payer healthcare, but messaging about health disparities was largely absent from local print media.

Local media also made no connection between coal mining and the growing body of research suggesting that mining is contributing to the cancer burden in the region. Such a difficult pill remains bottled up, just as does long-standing evidence that mining actually limits economic growth and increases poverty in the region. The coal industry continues to campaign to promote the notion that the economic identity of the region is based in coal production and this message adds an emotional tone of resentment and bitterness to efforts to reduce poverty and, by association, efforts to address health disparities.

Public health voices need to take a stand in support of research indicating that the

regional cancer burden is exacerbated by coal production. Rather than taking the economically rational position that cancer prevention is tied to individual lifestyle choice, a bolder position that focuses on inviting public discussion of research findings about environmental issues that affect cancer is needed. This would shift coalitional politics away from the process of shoring up and sustaining community relations that instrumentally support fund-raising relationships towards a new set of ties grounded in local, regional, and national concerns about environmental pollution and the marketing of carcinogenic products.

Such an effort would be unlikely to damage the services being offered by the American Cancer Society, which has proven to quite adept at raising funds with or without the presence of a local cancer prevention service system. These services can still be available in the community. Instead, coalitions would reorganize its efforts at developing community participation and empowerment to assure that those voices most likely to be marginalized by local and regional power relations will have a forum for being heard. New energy could be infused into coalitions by expanding membership beyond health professionals by drawing on organizations like Kentuckians for the Commonwealth and other groups concerned about environmental conditions in the region as well as the increasing privatization of the healthcare system.

This shift at the media level would open up possibilities for addressing concerns at the coalition network level. The stress in the national media, especially through the promotion of “pink” product campaigns, tends to be on the lived bodily experience of middle-class and upper middle-class, white females. This emphasis ignores the place of males generally who are diagnosed with cancer and it marginalizes the lived bodily experiences of working-class women, whether women of color or white women, who may not have the economic means to access many healthcare services or the “pink” consumer products, offered in the marketplace. These women may not have the means to make complex lifestyle changes that require the economic resources to consume expensive beauty, diet, and fitness products. Also, they are most likely to live in housing that is substandard and adversely affected by the environmental consequences of mining, waste disposal, water pollution and other environmental degradation.

This last point suggests that many people living in areas with low income families are

geographically concentrated in locations in the county that make access to services difficult, even as the healthcare social world attempts to consolidate locales in such a way as to promote “one stop” shops that situate a number of providers in health parks, possibly adjacent to the regional hospitals or county public health clinics. Transportation remains one of the most difficult obstacles to access for many poor community members. With the shift away from fund-raising, coalitions and public health agencies could expand advocacy efforts for low income populations in an effort to find solutions to community transportation problems among the poor.

And Finally

I set out to explore the notion that local cancer prevention coalitions were “grassroots” organizations concerned with community participation and empowerment. This empowerment was suggested to include an effort to reduce health disparities in eastern Kentucky counties which have a long history of poverty and environmental injustice. What I have found suggests that the neoliberal political bias that has influenced health policy over the past forty years has tended to reframe community participation and empowerment in individualistic, free market terms that exclude the possibility of collectively confronting local power hierarchies that help to maintain the very health disparities the coalitions claim to want to address.

Coalitions are under resourced and cannot compete with national trends toward large-scale fund-raising as the primary focus of cancer prevention and control. They are products of the local culture to the extent that they accept and ignore the ongoing health consequences brought on by the mining industry and fail to confront the place of mining in maintaining economic as well as environmental injustice. Until coalitions and their sponsors at the regional, state, and national level accepts the need to confront these economic and environmental injustices as part of their mission, they are unlikely to make more than an incremental difference in the cancer burden in the region

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Vita

Place of birth

Kingston, NY

Educational institutions attended and degrees already awarded

1978-1985 BFA Music (Marshall University, Huntington WV)

1985-1989 MA Counseling & Rehabilitation (Marshall University, Huntington WV)

1997-2002 MA Sociology (Marshall University, Huntington WV)

Professional positions held

2012-2013 Part-time Instructor (Bluegrass Community & Technical College, Georgetown College, Midway College)

2010-2011 Part-time Instructor (University of Kentucky)

2008-2010 Research Assistant (Prevention Research Center, Department of Internal Medicine, Markey Cancer Center, University of Kentucky)

2006-2007 Teaching Assistant (University of Kentucky)

2005-2006 Research Assistant (Appalachian Center, University of Kentucky)

2004-2005 Teaching Assistant (University of Kentucky)

2001–2002 Therapist (Family Services, Huntington, WV)

1997–2001 Therapist (Family Guidance Center, Ironton, OH)

1995–1997 Therapist (Pathways, Inc, Morehead, KY)

1992 – 1995 Therapist (CareUnit, Inc, Ashland, KY)

Scholastic and professional honors

Recently received funding through National Cancer Institute to conduct dissertation research in Appalachian eastern Kentucky

Received a Methodological Excellence Grant to attend Network analysis training with Stanley Wasserman at the University of Michigan's Inter-University Consortium for Political and Social Research (ICPSR), Summer 2008

Received a grant from the Appalachian Community Cancer Network to do a pilot project, The Impact of Regional Culture On Framing Substance Use Issues in an Appalachian Community, which is related to how health prevention messages are understood by local people in Lee County, KY

Received James S. Brown Graduate Student Award for Research on Appalachia, Summer 2006, to do research on how Appalachia was portrayed in media stories about OxyContin addiction in eastern Kentucky

Received Beers Fellowship Developmental Grant. Summer 2005, to do research on representations of Appalachia and violence in the Appalshop film, Stranger with a Camera

Professional publications

Brother's Keeper: Toward a Model of Community Violence. Publisher: VDM Verlag Dr. Mueller, Pub. Date: August 2007, ISBN-13: 9783836425773, 260p

Extending Psychotherapeutic Strategies to People With Disabilities. Journal of Counseling & Development; Nov/Dec89, Vol. 68 Issue 2, p151, 4p

Name

George F. Bills