"If it's a woman's issue, I pay attention to it": Gendered and intersectional complications in *The Heart Truth* media campaign

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Abstract

This cultural study explores the nexus of cultural studies, knowledge production of communication campaigns, and intersecting identities to offer insight on how to better design meaningful campaigns for publics. This research examines how women understand, perceive, and interpret a heart health communication campaign. Fifty-nine women from various racial, ethnic, geographic, and socioeconomic backgrounds were interviewed. Women appreciated and critiqued the campaign according to role-fulfilment as family and community information-givers, tensions about race and gender representations, hegemonic health discourse, and communities' lived and everyday barriers. The study highlights the limitations of traditional campaign segmentation approaches, demonstrates the need for exploring cultural meaning-making at the beginning of campaign development, and stresses the importance of studying intersectionality of identities in mediated environments.

Introduction

Scholars have explored reasons why public relations campaigns often fall short of effectively communicating prevention behaviours (see Snyder, 2001). This paper suggests that misunderstandings of the cultural groups and their lived identities by the campaign producers lie at the heart of the "misses" in health campaigns (Dutta, 2007; Lupton, 1994). This cultural study explored how consumers of a public health campaign perceived their identities to be linked to the messages sent to them about a health risk. This paper contributes to the broader field of public relations by: (a) highlighting the hegemony of national health campaigns, (b) emphasising the limitations of traditional campaign segmentation approaches; (c) demonstrating the need for exploring cultural meaning at the beginning of campaign development; and (d) stressing the importance of studying intersectionality of identities in mediated environments.

Context of the study

According to the American Heart Association (2007), cardiovascular disease (CVD) is the leading cause of death in women in most of the developed world, and kills over 500,000 American women. Black/African American women have the highest mortality rate from CVD, and Latinas suffer at increased rates from contributors to heart disease (National Heart, Lung, & Blood Institute, n.d.b). Despite the prevalence of CVD among US women, research about women's awareness of CVD risks reveals gaps in knowledge about CVD (Robertson, 2001).

The Heart Truth campaign

The US NHLBI launched *The Heart Truth* in 2002 to educate women "that heart disease is the #1 killer of American women" (NHLBI, n.d.a). A sub-campaign initiative was launched in 2005 for women of racial minorities (n.d.b.). The campaign's overall goal is to "give women a personal and urgent wakeup call about their risk of heart disease" (NHLBI, n.d.c). A red dress is the "national symbol for women and heart disease awareness," which NHLBI claims "links a woman's focus of her 'outer self' to the need to also focus on her 'inner self', especially her heart health," (NHLBI, n.d.a) (see **Figure 1**, below, for a public service announcement from the campaign). The campaign has downloadable material on its website and enacts myriad special events in major cities.

Vardeman-Winter, J. & Tindall, N. T. J. (2010). "If it's a woman's issue, I pay attention to it": Gendered and intersectional complications in *The Heart Truth* media campaign. *PRism 7*(4): http://www.prismjournal.org

Figure 1: Public service announcement for *The Heart Truth*

Literature review

Cultural studies and public relations campaigns

Campaign designers may not recognise the cultural assumptions they inject into their research and campaigns. Thus campaigns tend to be based on knowledge as understood and produced *by* the institution *for* the ultimately exclusive benefit of the organisation sponsoring the research and campaign (Dutta, 2007; Rakow, 1989). As a consequence, culture is often narrowly defined for campaigns, such that cultural symbols, identities, languages, and meanings may be misunderstood in the transformation of the code from the culture to the campaigner then back to the culture (Aldoory, 2001; Lupton, 1994; Sison, 2009).

Common effects of these cultural differences include messages that do not resonate with consumers (Dutta, 2007). Another consequence when campaign designers cross cultural boundaries is that consumers feel campaigners are "talking down to them," and, they reject the messages (see Vardeman, 2005). To understand the 'misses' that occur in campaigns, communication scholars explore how the information – or truths – portrayed in campaigns are produced and consumed (Rakow, 1989; Salmon, 1990).

In response, social scientists should "stand outside of the paradigm of researchers and practitioners who are interested in improving the effectiveness of information campaigns in order to see them from a different perspective" (Rakow, 1989, p. 165). Critics also believe change should come from within a group rather than from an outsider that may have its own agenda driving the project rather than the indigenous group's best interest (Parrott & Steiner, 2003).

Cultural studies examine the never-ending tension social groups experience in self-identification in relation to external – possibly contradictory – forces (Frow & Morris, 2003; Nelson, Treichler, & Grossberg, 1992). Mass communication and public relations entities constitute external forces that impose privileged meanings upon consumers for the purpose of commodifying behaviours. Thus, conducting cultural studies of public relations campaigns is relevant to determine the dominant meanings perpetuated and resisted by opposing social forces.

Few cultural studies exist that uncover how knowledge is produced in public information campaigns (Acosta-Alzuru, 2003; Curtin & Gaither, 2007; Gaither & Curtin, 2008; Moffitt, 1994). Even fewer studies have examined public health campaigns (Aldoory, 2001; Briones, 2010; Tindall & Vardeman, 2008; Vardeman-Winter, 2010). One reason these types of studies are not often conducted is the difficulty in finding campaign designers willing to participate since cultural studies as a methodology "encompasses a set of approaches that attempt to understand and intervene into the relations of culture and power" (Grossberg, 1993, p. 89).

Studying campaign consumers' perspectives is relevant because consumers can discuss their tacit cultural knowledge that producers may have overlooked. Tacit knowledge contrasts with universal forms of knowledge held by authoritative bodies, which are encoded into campaign messages (Moffitt, 1994). These contrasts reify hegemony in media campaigns, which "is fraught with contradictions because media texts are crucial sites of negotiation and friction over meanings that strive to be established as dominant, or naturalised as 'common sense'" (Acosta-Alzuru, 2003, p. 273).

Samples comprising exclusively marginalised groups like women from racial minorities are rare in public relations research (Pompper, 2005). However, they help us best understand the depth and breadth of problems when campaigns reinforce hegemonic principles and don't recognise the tacit cultural knowledge of those needing better health information. By not using purposive samples of marginalised groups when studying topics that disproportionately impact non-White groups, our discipline reifies the dominant values of what public relations research does, rather than realising the potential of what public relations research can do to ease the tension campaign messages bring to marginalised groups.

Hegemony and health communication campaigns. A foundational concept in cultural studies, sociology, and mass communication, hegemony is the process by which privileged meanings are fortified in a society to sustain political and economic systems (Gramsci, 1971). Hegemony "helps explain the stability of the unequal distribution of wealth and power in apparently democratic societies" (Hess, 1997, p. 115). Media organisations are social institutions that enable wealthy groups (advertisers and sponsors) to access less powerful groups (consumers) to persuade them to buy goods or support debated issues. The processes that media organisations employ preserve privileged meanings of commodities and exchange.

Identity is crucial to the study of media hegemony. Taken-for-granted systems are enabled because of dominant meanings about powerful and less powerful groups, such that "power relations of gender, ethnicity, class and identity are struggled over" (Acosta-Alzuru, 2003, p. 270). As such, antiracist and feminist critiques on cultural practices in communication have brought forth studies of counterhegemonic movements (Gramsci, 1971; Haraway, 1997; Hess, 1997). Less powerful groups perform counterhegemonic acts by inverting dominant meanings to restructure a discourse. Communication scholars should learn these new meanings about risks to encourage more encompassing discourses (Hall, 1993).

How cultural groups negotiate their lived experiences and identities with mediated, privileged contradictions is the crux of cultural studies. We attempt in this study to investigate how cultural groups perceive their identities impact their readings of mediated health texts. We also predicted that hegemonic meanings of health have neglected the complicated intersectionality of consumers' identities, thereby contributing further to the 'misses' in health campaigns. We sought to learn how consumers negotiate contradictions of multiplying identities.

Intersectionality, identity, and segmentation of publics. Some public relations scholars have explored how publics' identities determine their information-seeking behaviours (Aldoory, 2001; Kim, Shen, & Morgan, in press; Sha, 2006; Sison, 2009; Slater, Chipman, Auld, Keefe, & Kendall, 1992; Tindall & Vardeman, 2008; Vardeman & Aldoory, 2008; Vardeman-Winter, 2010). Gender has been explored in only a few studies (Aldoory, 2001; Slater et al., 1992; Tindall & Vardeman, 2008; Vardeman & Aldoory, 2008; Vardeman-Winter, 2010). Some scholars have argued that gender impacts communication behaviour because women may be involved differently than men are in health communication situations (Aldoory, 2001; Vardeman & Aldoory, 2008).

This study does not isolate gender as a prevalent identity. Gender is incorporated as one identity among others in an intersectionality framework (Collins, 2000; Crenshaw, 1991; King, 1988; Weber, 2001; Vardeman-Winter, Tindall, & Jiang, 2010; Zinn & Dill, 1996). Studying how publics' identities simultaneously intersect is not an exercise in adding together the distinct impacts of separate identities; instead, it is an effort to understand the systemic structures, politics, and representations that concurrently privilege and marginalise publics (Crenshaw, 1991; Shields, 2008).

Particularly in a globalising economy powered by digital, dynamic media, public segmentation strategies "neglect the increasing mobility, diaspora and multicultural mix of global public relations audiences" (Sison, 2009, p. 1). Therefore, the need to adapt segmentation strategies to accommodate more complicated publics is pertinent. Scholars (Kim, Ni, & Sha, 2008; Sison, 2009) have attempted to re-conceptualise traditional segmentation approaches by broadening the communication behaviours that define active publics. Some limitations persist in traditional and current segmentation strategies that neglect cultural principles and beliefs (Sison, 2009).

The impact of intersecting identities has not been addressed fully in most communication campaigns (Aldoory, 2009; Sison, 2009). The persistent exclusion of discourse on the constructions of race, gender, ethnicity, nationality, and sexuality among other identities in the development of public relations theory and practice hinders how practitioners

communicate effectively with publics that enact and engage organisations (Aldoory, 2009; Pompper, 2005). Thus, this study attempts to expand upon re-conceptualisations of traditional segmentation theories by asking a historically marginalised group about their experiences of interacting with media.

Research question. The purpose of this study was to explore the role of identity in a heart disease media campaign from the perspectives of women of racial minority groups. The guiding research question was: *How do women from racial minorities believe their identities impact their perceptions of a media health campaign?*

Methodology

We chose a cultural approach for our research, and we used qualitative methods to gather and analyse data. We conducted in-depth interviews with 59 women from racial minorities. Using multiple samples increased the validity of our findings because they come from different sources in a "display of multiple, refractory realities simultaneously" (Denzin & Lincoln, 2003, p. 8).

Sampling and procedures

We first recruited participants using selective sampling to find specific types of participants (Lindlof & Taylor, 2002). We sent emails to personal contacts, placed flyers in public places, and sent out announcements on workplace intranets to solicit participation. African American, Latina, Asian and Asian American, and Native American women 18 years and older were eligible to participate. We asked these participants if they knew other women of their same race who may be interested in participating. For their time and help, participants received monetary incentives[1]. Interviews were conducted in convenient places for the participants. Interviews lasted between 30 and 90 minutes.

Interview protocol. We used an open-ended protocol to obtain the data (see Appendix A for the protocol). We asked women if they recalled any messages or conversations about heart disease to determine the extent to which women were familiar with heart disease media, messages, communication, and knowledge. We did this also to determine if the women had already seen *The Heart Truth* messages.

We used two communication theories to frame our questions: the situational theory of publics (Grunig & Hunt, 1984; Grunig, 1997) and the health belief model (Rosenstock, 1990). These theories helped identify if the information sent to them targeted them appropriately. They also helped solicit details about participants' media usage for health information, their personal beliefs about the health risk, and their behavioural intentions around heart disease.

We could not rely on the possibility that participants would link their personal assessment of the media campaign to their culture (although many did without our prompting). Instead, we asked questions to elicit discussion about the broader context through which participants saw their identities as linked to media representations of themselves. We sought to find out if there were differences between how the women perceived the intended messages versus how the women actual perceived the messages. These differences would get at the hegemonic and counterhegemonic practices.

To uncover intersectionality, we also looked for ways in which women's identities existed multiplicatively. One way we did this is by contrasting their responses to the question, "How do you feel about heart disease as a(n) African American/Hispanic/Asian woman that may be different or unique from other groups affected by heart disease?" In our analysis, we looked for instances in which women talked about their identities separately versus ways they talked about their identities simultaneously (Vardeman-Winter et al., 2010).

The textual object

We introduced several materials from *The Heart Truth* campaign for the women to peruse at their personal pace and choice. We offered about 12 materials to the participants. This process of letting the women sift through a range of materials may be aligned with how

[1] Funds were available through a grant to study "diversity and health communication" from the Public Relations Society of America Foundation.

they realistically examine health materials in a doctor's office or online.

Data analysis

Data analysis was modelled after the constant comparative method (Glaser & Strauss, 1967), and we used open-coding procedures to look for emerging themes (Miles & Huberman, 1994). A data reduction was employed to organise and categorise data by theme (Bogdan & Biklen, 1992). Similar themes were grouped together that answered the research question. As themes emerged, they were compared to previous themes (constant comparison method) to determine the consistency of certain themes versus sporadic, outlier themes.

Participant demographics

Fifty-nine women were interviewed in six metropolitan areas of the United States. Thirty-one Black and African women, 10 Asian and Asian American, six Latina/Hispanic women, four Native American, one Southeast Asian American, and seven biracial women were interviewed. The majority of women were in their 20s, 30s, and 40s. A few were either 18- or 19-years old, and about 10 participants were between the ages of 50 and 65. Seven participants listed a country of origin outside of the United States. Most of the participants made under $30,000. None reported she had heart disease, although some women reported having hypertension, high blood pressure, and problematic cholesterol.

Results

Women discussed how they understood the broader contexts of health information sent by authoritative bodies like media, government, doctors, and pharmaceutical and food companies. The women believed their identities impact their reading of *The Heart Truth* through their *role-fulfilment as family and community information-givers*, their felt *reflective tensions of race and gender representations*, their experiences of *struggle between hegemonic health discourse and community's lived barriers*, and their *design of messages that counter everyday barriers*.

Role-fulfilment as family and community informative-givers

Women immediately connected heart disease with relatives or friends diagnosed with heart disease. But, many women did not necessarily perceive the messages as targeting them. Instead, some women said they would pass the information to their mothers, aunts, sisters, or friends they felt were at risk. As the hubs of networks, the women could influence health decisions for themselves and for others. Thus, common among the participants was a tacit cultural understanding of being a community advocate, a mother, a wife/partner, a daughter, a sister, and part of a discourse about the community's health.

Some felt there was no difference among how women perceived the issue since "it's a women's issue." For example, one East African woman, Marie, felt targeted by *The Heart Truth* messages because she is a woman:

> Just because I am a woman. Usually when they say African American woman or Latina woman or White woman, it doesn't really have an effect on me. I just see it as a woman's issue. I don't really pay attention to the percentage. But if it's a woman's issue, I pay attention to it.

Several of the women were surprised that they never knew that heart disease was the top killer of women because they previously identified heart disease as a "man's disease." Traditional heart disease discourse portrayed women as the caregivers and counsellors for those needing help managing good health. The campaign provided them with knowledge that conflicted with their previously held information about their relationship to the disease.

Reflective tensions of race and gender representations

Not all women felt the messages were relevant merely based on gender. Some women connected with the messages because of similarities of race or ethnicity. For example, Rosario, a younger Hispanic woman, said gender representations do not resonate with her:

> I think that has to do with my self and my identity development where I've always identified myself as Hispanic

> first – I've always felt a kinship to other Hispanics, but I've never felt a kinship toward other women. I don't feel like, oh, we're all women, and I've never gotten involved with women causes. So something like this targeting women is not something I'm really going to connect with.

These essentialised representations of women from racial minorities ignited women to critique the campaigns and in some cases, defend their races and ethnicities. Many talked about social and political stigmas about their race that they saw reified in the campaign. For example, a few women felt disappointed that the African American women shown in the materials were light-skinned Black women instead of a mixture or dark-skinned Black women. Also, some women felt the messages "talked down to them" because they perceived the messages only talked about the negative trends in their cultural groups.

Differently, several women felt the representations of them in the campaign respected their gender and race. Some women felt more involved with these messages because of the emphasis on race, as perceived by Shachi, a Southeast Asian American woman in her 30s:

> To some extent, I feel targeted because they are speaking to women and women of color. That feels different – it's not just a general ad with no face to it. They are trying to reach out to me in terms of being a woman and a person of color. This one speaks directly to Latinas, but I think in these general ads, just because of the diverse faces, it's not just white faces. There are faces, and they are diverse faces, and I identify with that.

These women tell us that the representations of women from racial minorities provoke conflicting feelings in them or in their communities. Some women rejected elements or all of the messages because they perceive the campaigners essentialised them and built a hegemonic perception that women from racial minorities look a certain way and find solidarity through gender. These active rejections are counterhegemonic practices (Gramsci, 1971) that speak to the multitude of conflicting ways that women from racial minorities make meaning of risk messages about them. These tensions indicate a wealth of opportunity to discover how women from racial minorities can create and use media to make it work for them and their communities.

Struggle between hegemonic health discourse and community's lived barriers

Women talked often about "my community" or "my culture." As envoys of their communities, women discussed the problems they have observed or experienced in their cultures' efforts to acclimate to American ideals of healthy living. This campaign exposed conflicts these intersections bring to women who think about how their cultures can change for the better. For example, several Hispanic, Black, and South Asian women said that their cultures' foods may contribute to health disparities. One Latina, Pura, pointed to cultural reasons why Latinas may have more risk for heart disease: "Some of the foods we eat may be contributing to heart disease. I guess, traditionally, inactivity – some of these things that may be attributed to heart disease."

Similarly, Sandy, a Black woman in her 40s, thought her culture's attitudes toward food may perpetuate health problems. She has changed her eating habits to be healthier than those she had growing up. Now, Sandy cooks healthier foods for her husband because of his potential health problems, although he continues to eat foods she considers traditional but unhealthy:

> [My husband and I] do a little cheese and crackers and olives and little different types of things for snacks, when he will allow me not to cook some crazy fried meal. But when I tell all my sisters and family members that, they're like, you're not eating like a black person. And I'm like, I don't know what you mean by that, that's kind of stupid, you know, I eat what I like. So, somehow down the road years ago, somebody has put in somebody's mind that black people eat one way, and let's just say, white people eat another way…when it comes to black people eating certain foods, it's the mashed

> potatoes and the collard greens, the fried chicken, pork chops, that's expected…that was kind of a weird thing, to think that black people are only supposed to eat [certain foods].

When women talked about the barriers their cultures have to attaining health, they commonly spoke of an intersection between their community's financial barriers and their food/activity norms. Many women said heart disease prevention is difficult because it is expensive to buy healthy foods and purchase gym memberships. Tulia, a Latina in her 30s, explained how class interacts with health through cultural norms:

> Traditionally, there hasn't been a lot of activity in terms of working out and running and taking care of yourself in that way. Part of it may be income, like, that's not a high priority on my list. It's never been a high priority on my mother's list. She works and she takes care of the family…but [it's] not a priority. That's a luxury, to a certain extent.

It seems impossible to split Sandy's and Tulia's identities from the historic health beliefs their cultures have about food and physical activity. Sandy's role as a wife is intricately linked to her being a Black woman with responsibilities of preparing traditional foods for her husband. Tulia's role as a watchful daughter is simultaneously expressed as a member of a cultural group historically known to have little money for luxuries.

These women recognise the complexity they face when their cultures are pitted against the industrial American complex of health, food, and exercise. American hegemonic ideals for health seem to diminish these cultures' everyday lived experiences of race, class, and gender (Acosta-Alzuru, 2003). The campaign renders some suggestions for improved health impotent for actual use by these cultures (Hall, 1993). The women's recognition of these hegemonic ideals is an important counterhegemonic practice (Gramsci, 1971; Haraway, 1997). However, the extent to which campaign designers attend to these cultures' real limitations is unknown given the limited use of cultural exploration during campaign development (Dutta, 2007).

Design of messages that counter everyday barriers

The participants engaged in the counterhegemonic practice of imagining how health messages could be designed better. These discussions focused on helping women become more heart healthy in light of the everyday barriers they experience. Participants' recommendations cantered around the need to "use younger women, start the discussion earlier," as Bernice, a Black woman, suggested:

> To me it's never too late, because I'm 44, so I feel like it's not too late for me right now, but I guess it's attempting to educate us on the things that we shouldn't be doing so much, as women…[the materials address] just women of color at a certain age, but it doesn't [address] my daughter's age, which is 25. It's not even teaching, like my children. I don't know if it's teaching younger people that are of color. If they were to get to my age, how much is it teaching them? So that when you get to the problem stage, what if you didn't have enough prevention way ahead of time?

Younger women also said that the age differences were pertinent because younger women do not have as many family obligations as older women. Younger women may have more cognitive and physical ability to dedicate to persuasive health messages.

Similarly, several participants perceived time constraints as the reason they cannot use the campaign's information:

> About this recipe brochure: it's just recipes, it's obviously targeted toward the demographic of women who are more likely to be stay at home moms, whereas women our age are probably going to be two parent households where each are working and may not have time to prepare a meal that has 15 ingredients like this, so it doesn't seem to be targeted towards me personally, so I might be less likely to pay attention to

> it. But I would if I were sitting in the doctor's office and actually had time to read something like this. I would probably take it with me cause I can see that the content is relevant...

The women's recommendations signify cultural, counterhegemonic readings of the campaign materials, and they tell of why messages did not resonate with some participants (Acosta-Alzuru, 2003). They also indicate the vast potential of cultural groups to contribute to their own community health improvement (Parrott & Steiner, 2003). These women's suggestions encourage future campaigners to engage publics in the development, testing, refining, and disseminating of the materials throughout their communities (Rakow, 1989).

Discussion

Overall, women from racial minorities interviewed said *The Heart Truth* campaign held important messages about heart disease. However, women also critiqued the campaign based on their perceptions that the campaign essentialises women and does not consider the everyday intersections that create barriers for them against changing their health behaviours. Participants provided ways that messages could speak to them better, which constitute counterhegemonic readings that behove campaign producers to adapt future campaigns.

Theoretical implications

Cultural studies and public relations campaigns. This study validated the importance of using cultural studies to examine the usefulness of public relations campaigns (Curtin & Gaither, 2007). By exploring how consumers' identities are linked to their perceptions of a health topic in the media, the findings suggest that some of the universal forms of knowledge conveyed by the campaign producers did not match the tacit cultural knowledge consumers believe about their health (Moffitt, 1994). For example, one Latina perceived a lack of translation between traditional Hispanic and US foods: "I think the perception is that a lot of Latina women cook. There's nothing in here about what is it about your cooking that could make your family overweight or obese?" Thus, conducting cultural studies in formative research may bridge gaps in dominant-tacit knowledges.

Future research should be conducted to learn the types and depths of cultural understanding sought by communicators. Researchers can also investigate the motives driving the formative research that communicators conduct and the perceptions communicators have of employing cultural studies in their processes. Concepts that could be incorporated into formative campaign design include an examination of "tacit cultural knowledge" held by consumers and "universal forms of knowledge" held by producers (Moffitt, 1994). Studying both forms of knowledge highlights the hegemonic versus marginalised understandings about a health behaviour. Also, directing communication first to the marginalised groups experiencing health disparities (Pompper, 2005) forces communicators out of their comfort zones and into an experiential process of learning the web of complications marginalised groups live in adhering to health campaign suggestions.

Hegemony and health communication campaigns. This study proposed to uncover the hegemonic discourse of a health campaign. Women expressed several contradictions about the privileged meanings of heart health in the campaign (e.g., women may betray their culture if they prepared 'white' foods). What may have seemed like common sense to campaigners (e.g., cooking vegetables) translated into a 'miss' for some participants (e.g., recipes do not account for making cultural foods healthy, the limited time women have to prepare healthy foods, and the prohibitive cost of healthy foods). Also, hegemonic meanings of health included that *identities are universal* (e.g., all Black women portrayed were light-skinned), *identities are singular and additive* (e.g., Latinas' varying socioeconomic statuses were un-discussed), and *identities are based primarily on demographics* (e.g., women portrayed as raced, aged, or gendered, but not as information-givers or community envoys).

These contradictions illuminate a *systemic health campaign cultural miss*: without learning and portraying the complicated nature about health in women's everyday lives, large

organisations seeking to change health behaviours are destined to miss their target. The effects of a systemic health campaign cultural miss are (a) essentialisation of cultural groups, (b) a neglect of intersectional lived experiences, (c) incongruent understandings of 'common sense', and (d) an emergence of counterhegemonic practices (which may or may not be healthy). This systemic health campaign cultural miss is important to study because of the billions of dollars deployed in health care systems worldwide by global commercial, non-profit, and governmental organisations that attempt to reduce health disparities and epidemics. As communication is fundamental in changing behaviour, targeted communication is destined to miss its opportunities without understanding the tiny, nuanced reasons messages do not resonate with consumers.

Intersectionality, identity, and segmentation of publics. The importance roles of identity and intersectionality in public relations segmentation were affirmed in the findings. The data demonstrated that the participants' lives exist within intersectional contexts where their roles are gendered and raced (is a wife's cooking 'Black enough'?) and their cultures are classed and gendered (women's roles of convincing elders to eat American healthy foods, trying to make healthy cultural foods without appropriate recipes, and finding affordable health foods and outlets for physical activity). This study validated previous findings (Aldoory, 2001; Tindall & Vardeman, 2008; Vardeman-Winter, 2010) that representations of gender, racial, and ethnic identities resonated with women as well as divided women in their appreciation of the campaign messages.

This study questions the persistence of traditional segmentation strategies around basic, large-scale demographics like racial and gender identities. Since women seemed to be more involved with *The Heart Truth* messages based on their community-related and multiplying identities (rather than gender and racio-ethnic identities alone), these findings imply that the primary identifications of gender, race, and ethnicity have been sullied by the frequency of campaigns that use those identifications to connect with segmented groups (Aldoory, 2001, 2009; Sison, 2009). Women's resistance to ascribed identities leads women to reject simple, broad categorical imperatives that campaign messages reinforce. Instead, women rely on their social, collective selves to confirm and differentiate their identities from media portrayals.

Learning such complexities about our publics' reading of media messages reminds us that media portrayals have failed to recognise the complicated dimensions of identity, particularly among the matrix of intersectionality and health. There is not a simple, singular fix to this problem. Instead, researchers and communicators must first pursue more meaningful segmentation theories that acknowledge the intersectional frameworks in which publics live (Aldoory, 2009; Sison, 2009; Vardeman-Winter & Tindall, 2010; Vardeman-Winter et al., 2010). Segmentation strategies should also account for extant social and political systems that maintain marginalised positions for those communities. Also, researchers should look for case studies in which organisations have employed innovated segmentation strategies, the cultural studies approach, and early community engagement.

Practical implications

Campaign designers can use these data to craft messages more thoughtfully for women from racial minorities. Campaigners can also try to understand women from racial minorities' perspectives on health not as the 'other' to white women, but equally or more deserving of attention at the initiation of campaign work, particularly when health disparities exist.

The women also suggested that similar campaigns should encourage younger women to take advantage of their physical abilities, lack of family commitments, and their acclimations to American customs so they can adopt heart healthy behaviours now and sustain them for life. Communicators should also suggest behaviours that do not take as much time to conduct; give women behavioural suggestions and information in intervention spots where they will be able to spend cognitive time to process the information; and contextualise the information within everyday

barriers, like encouraging younger generation Latinas help their less-acclimated parents find affordable foods that incorporate their ethnic ingredients into healthier recipes.

Limitations and future research

Print materials from a campaign were used, but in their actual experience, women may come into contact in with other traditional campaign techniques. Therefore, the method of eliciting actual, immediate meaning-making is difficult. While this study reflects a nearly unprecedented public relations exploration of women from racial minorities as the public, future research must talk with more women from low socioeconomic backgrounds. Talking with producers of campaigns will also provide deeper understandings of challenges communicators face in designing messages that are meaningful but not overused.

Some patterns found could be critiqued as leading because of efforts to investigate how publics perceive their identity to influence their decision-making. Although we did not explicate identity according to race, gender, class, community, age, and familial status, these identities were implied in some questions. These questions may have encouraged the participants to think about how those identities alone contribute to their decision-making. In a future study, other identities can be discussed by asking about their impact, such as geography, amount of travel, level of education, and family composition.

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Appendix A: Interview protocol

1. What does the word 'health' mean to you?
    Probe: What is one of your major health concerns today?
2. When I mention heart disease, what do you think about?
3. What do you think heart disease means to your family and friends?
4. Where would you turn for information about heart disease? What places in your community can you turn to when you are concerned about heart disease?
    Probe: Which media do you use for information?
    Probe: What resources do you have to discuss concerns like heart disease?
5. What is an example of when you sought health advice from another person or information source?
6. To what extent have you seen or heard any messages regarding heart disease?
    Probe: How often do you see or hear messages about heart disease?
    Probe: What did they say/communicate to you?
    Probe: Please describe the messages.
    Probe: What did these messages make you feel?
    Probe: What did these messages make you think about?
    Probe: Have you changed any of your behaviours based on these messages? If so, what?

Please look over the materials from the heart disease campaign.

7. How well do you feel like the messages in these materials address your needs for information?
    Probe: What do you feel the messages are trying to convince you of?
8. How do these messages make you feel?
9. To what extent do you think these messages are targeted to you?
    Probe: If they are not, whom do you believe the messages target?
    Probe: How do these messages address your community's or your culture's for information?
10. How well do you feel you comply with the messages sent to you regarding heart disease?
    Probe: How does your level of compliance make you feel?
11. How would you change the messages if you could make them 'talk' to you better?
12. If you could change the way that women receive information about heart disease, how would you change it?
13. To what extent do you feel capable of avoiding or maintaining heart disease, based on the information you have seen here about it?
14. What are reasons why you would not be able to manage heart disease the way you would like?
    15. After viewing these pieces, how do you feel about heart disease as a(n) African American/Hispanic/Asian woman that may be different or unique from other groups affected by heart disease?
16. If you feel heart disease is an important concern for your community, what would you do to change the situation?
17. Is there anything I left out or did not ask about that you feel is important for me to know?

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