

BLACK WOMEN'S PERCEPTIONS OF HEALTH: CONSIDERING CULTURAL
IDENTITY AS AN ANTECEDENT FOR THE SITUATIONAL THEORY OF
PUBLICS

A Thesis

Presented to

The Jack J. Valenti School

of Communication

University of Houston

In Partial Fulfillment

Of the Requirements for the Degree of

Master of Arts, Public Relations

By

Jasmine C. Powell

May, 2016

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ABSTRACT

The purpose of this study was to understand Black women's perceptions of health, specifically in regards to HIV/AIDS, and the ways in which their cultural identities influence health decisions according to the situational theory of publics. This study included in-person interviews with 15 Black women who attended a hip hop awareness concert or who were in the target audience, but chose not to attend. The following research will help public relations practitioners effectively predict the communication behavior of Black women based on the understanding of their constraints.

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INTRODUCTION

HIV/AIDS Epidemic in the United States

First observed in the United States in 1981, the human immunodeficiency virus (HIV) attacks and destroys T-cells or CD4 cells, which are a major part of the immune system, according to AIDS.gov (n.d.). This attack weakens the body's defense and can progress to the acquired immunodeficiency syndrome (AIDS), which is diagnosed after a person contracts any HIV-related infection or if his or her T-cell count drops below 200 (www.AIDS.gov, n.d.). By 1998, 30 million people were living with HIV, eight million people had died from AIDS-related illnesses, and the disease was named the primary cause of death among adults in the United States between 24 and 44 years old (Morris, 1998). While there is still no cure, U.S. researchers have re-categorized AIDS as a chronic illness that can be managed over time because of medical advancement (Morris, 1998). Meanwhile, the U.S. government has invested significant resources in prevention, care and treatment research (Office of National AIDS Policy [ONAP], 2010).

Morris (1998) argued that there are systematic motivators, including homophobia, government funding, and racism, that keep at-risk populations vulnerable to contracting the virus. During its early years, HIV/AIDS was labeled a gay man's disease because the first cases in the United States were gay men; however, a subsequent, major development in HIV research was the discovery that the virus can also be transmitted by heterosexual partners (Morris, 1998). In the United States, an estimated 3,561 women died of AIDS related illness in 2012, and by the end of that same year, researchers estimated that 117,797 women had died since the start of the epidemic, according to the Centers for Disease Control and Prevention (2015). Today, the majority of all new cases worldwide

are transmitted through heterosexual contact (Morris, 1998), and 84 percent of new HIV infections among women are attributed to heterosexual contact (www.AIDS.gov, n.d.).

While gay, bisexual, and other men who have sex with men (MSM) are still the highest risk population for HIV/AIDS, Black women have become the second highest risk group representing nine out of every 10 new infections in women (Black Women's Health Imperative, n.d.). The Imperative suggests that 1 in 30 Black women will be diagnosed with HIV at some point in her life, and that this health disparity is based on cultural, economical, behavioral, and biological factors, as well as a mixture of social and gender inequalities.

Government organizations such as the Centers for Disease Control and Prevention, and the U.S. Census Bureau, typically categorize HIV/AIDS statistics by age, race, gender and transmission category, and two or more categories are rarely considered together. For the big picture perspective that considers all of these factors in relation to each other, health communicators, public health researchers, and other interested parties must seek out smaller, sometimes newer organizations that usually focus on certain risk populations such as the Black Women's Health Imperative. Considering these factors together is crucial to developing solutions that meet the needs of marginalized groups, especially for women of color whose gender is overlooked in antiracist movements, and whose race is overlooked in feminist movements (Crenshaw, 1991).

A Communication Problem

This consideration of the ways in which a group of people's cultural identities work together is increasingly important for the communication field, and in particular, the public relations field, as it is the field that creates and deploys pro-health messages to

publics. This is because in order to strategically communicate with an organization's publics, public relations practitioners must understand each public's motivating factors for making decisions. These motivating factors are most often determined by the group members' life experiences, which are shaped by the combination of each individual's race, gender, class, sexuality, and other cultural identities. Although investigating a public adds time to campaign development, if practitioners consider publics' cultural identities together, rather than as unrelated demographics, then the organizations can produce messages that are more likely to reach their target audiences and speak to their cultural identities.

In the past, many HIV prevention campaigns have not always considered the unique experiences of their target audiences and focused vaguely on general preventative behaviors such as counseling and testing, which hindered effectiveness (Lear, 1995). For example, one popular critique of HIV prevention programs that focused solely on condom use, which is one of the central prevention methods for HIV (Stephens et al., 1998), was that they often ignored the social constructs that empower or limit an individual's ability to negotiate safe sex practices with her or his sexual partner (Holland et al., 1990). An example of an effective HIV prevention program is the use of messages that focus on risky behaviors rather than focusing on risk groups, such as drug users, sex workers and MSMs (Lear, 1995). Lear (1995) also recommended that the education programs should be ongoing and remain accessible since the students may hear the same messages for years, but they will not process them until they reach a certain age or situation.

To better understand the process of developing effective prevention programs, Phillips (1993) studied the techniques that certain organizations used to prepare for prevention campaigns. The research suggested that the use of objective questionnaires, which are based on general knowledge, cannot produce useful data concerning the underlying attitudes related to that knowledge. In contrast, subjective questionnaires can demonstrate these attitudes and beliefs and public relations practitioners or other communicators can analyze the data in order to better predict behavior (Phillips, 1993). Similarly, Phillips (1993) found that a person's perceived knowledge may actually be more important than her or his actual knowledge and that future research should consider the specific ways in which subjective knowledge is acquired. An organization that considers its publics' subjective knowledge in depth is more likely to effectively implement unique programming that communicates important messages in an attractive and understandable manner for its audience.

An Innovative HIV/AIDS Awareness Campaign

97.9 The Box, a Houston area urban radio station, hosted its first Hip Hop for HIV Awareness concert in 2007 (Currie, 2010). The annual concert, in association with the Houston Department of Health and Human Services, AIDS Foundation Houston, and a variety of local groups and businesses, targeted Black and Hispanic 15- through 40-year-olds and featured top hip hop artists (Currie, 2010). The only way to get tickets to the coveted shows were to get tested for HIV and other STDs at one of the numerous testing sites across Houston throughout the month of June each year. In 2010, the event organizers intended for 15,000 teens and young adults to complete the three-hour testing process, which also included sexual health education (Currie, 2010). They surpassed this

goal by testing 15,460 people – 113 of whom tested positive for HIV – over the span of 22 days (McNeese-Ward, 2010). This was an increase from their 2009 effort, which provided testing for 14,471 people – 86 of whom tested positive for HIV – over the span of 19 days (McNeese-Ward, 2010). This campaign produced high participation over an extended period of time because the organization made decisions based on the cultural identities of its target audience such as race and age.

Implications of the Study for Identity Research in Public Relations

With the growth of mediated discourse on culture in the United States, it is essential that cultural identity is considered in public relations scholarship (Sha, 2006). Since the 1970s, gender roles in our country have shifted from women acting solely as caretakers for their families, to women working in various industries and creating a balance between work and family life (Harris & Firestone, 1998). As these roles continue to shift, organizations must create messages for women that do not limit them to the traditional stereotypes of homemakers or secretaries. Additionally, the United States has a history of race issues between Whites and Blacks from slavery, to systematic barriers for voting and owning property, to current issues with increasingly-publicized acts of police brutality that have ended in the unnecessary deaths of Black men and women (The Truth of “Black Lives Matter,” 2015). In response to outrage with the current climate of our country, activists created the #BlackLivesMatter movement, which does not assert that Black lives are more important than other lives, but instead underlines the fact that that Black lives in this country have been devalued as if they do not matter (The Truth of “Black Lives Matter,” 2015).

Because of these experiences by marginalized groups, organizations must remain strategic in their communication with minority groups in order to make them feel valued and accepted into the larger society without devaluing their cultures (Collier, 1988). These challenges with communicating with members who have been oppressed because of gender or race intersect within women of color, who are situated in unique economic, social, and political positions (Crenshaw, 1991). When communication efforts targeted at women of color neglect their unique positions, these women are less likely to have their needs met or make any changes to their communication behaviors than other women who are racially privileged (Crenshaw, 1991).

Like all cultural groups, Black women's experiences affect the way they receive messages, make meanings of messages, and base their decisions. In the past, health communicators have made efforts to communicate with Black women as publics, but certain structural barriers like access to basic information or health insurance, have hindered the interventions' success when the group felt unrepresented in the messages (Tindall & Vardeman-Winter, 2011). In order to build mutually-beneficial relationships with Black women, communicators must discover more effective ways to communicate with women of color.

The purpose of this research is to understand Black women's perceptions of health, specifically in regards to HIV/AIDS, and the ways in which their cultural identities influence health decisions according to the situational theory of publics. The situational theory of publics is a well-researched public relations theory that predicts communicative behavior. The theory is helpful to this research because it provides a model for understanding how Black women interact with health messages. The results of

this research will benefit not only to Black women, but their families and friends, members of their communities, health communicators, medical providers and researchers, feminists, activist groups and government agencies. This work will provide a unique framework for building relationships with and spreading awareness to Black women as it focuses specifically on Black women's voices rather than all women or all women of color, which includes Hispanic, Asian American, and other minority women. There is a gap in current literature as race and gender are often considered separate from one another rather than considering them to be inseparable identities. As researchers continue to build the body of public relations research, it is crucial that time is invested into understanding this voice because being Black and a woman offers insight to understanding other minority groups.

LITERATURE REVIEW

First, I will review public relations literature that introduces and implements the situational theory of publics. Second, I will review cultural studies literature that reinforces the importance of understanding culture in order to effectively communicate with marginalized groups. Finally, I will review health communication literature as it pertains to intersectionality in order to understand the effects that cultural identities have on the receipt and interpretation of health messages.

Situational Theory of Publics

The strategic management of public relations is founded on the idea that organizations are constantly interacting with or operating for stakeholders and publics (Kim, Ni & Sha, 2008). In order to communicate effectively while working with limited time, funding, and networks, an organization should invest its resources in building relationships with the most important and relevant groups in its environment – its stakeholders (Kim et al., 2008). A stakeholder is any person or organization who can improve or diminish an organization's likelihood of reaching its goal (Kim et al., 2008). Thus, the process of strategically managing public relations first includes an organization's identification of its stakeholders, followed by its segmentation of those stakeholders into smaller groups (Grunig, 1997). These groups are called publics because each one shares a public opinion based on similar individual judgments developed through discussion and experiences (Grunig, 1997). Public opinion affects and is effected by public relations because a major responsibility of the public relations professional is to identify public opinions and communicate them with the organization's management (Grunig, 1997). Finally, the strategic management of public relations includes the

implementation of unique strategies and tactics to effectively communicate with each public (Sha, 2006).

The situational theory of publics is a repeatedly researched theory for managing public relations strategically. It can be used to help develop messages and design campaigns for stakeholders who communicate about an issue in similar ways (Aldoory & Sha, 2007). When correctly applied, the theory can reveal a group's perceptions and the situations that would facilitate communication (Grunig, 1997). Practitioners may then use their findings to segment the larger stakeholder population into smaller publics (Grunig, 1997). Additionally, practitioners can predict when an activist group may form based on individuals who are facing the same issues coming together and deliberately making decisions and performing actions to directly help or hurt the organization (Grunig, 1997).

The theory is composed of two dependent variables (DVs) and three independent variables (IVs) (Grunig, 1997). The first DV is *active communication*, also referred to as information seeking, which is the intentional act of searching for messages related to a specific topic of interest or concern to the public (Grunig, 1997). The second DV is *passive communication*, also referred to as information processing, which is the unintentional receipt of messages related to a specific topic, which is then processed by the receiver (Grunig, 1997). While the two DVs reflect communication behaviors, the three IVs determine the extent of the DVs, as they reflect a public's perceptions regarding a specific issue (Grunig, 1997). First, *problem recognition* is the detection of an issue and the belief that something should be done to correct it (Grunig, 1997). Second, *constraint recognition*, the center of this research, is the interpretation of power or the perceived barriers for correcting the situation (Grunig, 1997). In a study of the

effectiveness of a drunk driving campaign, Grunig and Ipes (1983) concluded that in order to affect a public's understanding and motivate action, a campaign must demonstrate the steps that members of the public can take to remove the constraints that restrict them from correcting the problem. Finally, *level of involvement* is the perceived relationship distance between the person and the situation (Grunig, 1997). Grunig and Hon (1988) further explained level of involvement using internal and external dimensions. The internal level of involvement is within a person's mind and the external involvement is a person's environment in the real world. Although the researchers found that internal and external dimensions did not directly affect communication behavior, they did find that the level of involvement was mostly determined by an individual's internal involvement.

Grunig (1997) also introduced four types of publics related to the IVs. This typology helps communicators predict a public's communication behavior. *Active publics* have high problem recognition, low constraint recognition, and may have high or low levels of involvement, which means that they will seek information and sometimes even pass the message on to others (Aldoory & Sha, 2007). *Aware publics* have high problem recognition and may have a strong level of involvement, but their high constraint recognition prevents them from taking any action (Aldoory & Sha, 2007). *Latent publics*, who are often the intended receivers of campaign messages, have moderate to high level of involvement, but low problem recognition, so they also will not take any action or recognize constraints (Aldoory & Sha, 2007). Finally, when a group is not intended to receive the campaign because they have a low level of involvement, and they do not recognize a problem or constraints, that group is a *nonpublic* (Kim et al., 2008). If a

practitioner can anticipate which types of publics will emerge concerning an issue and their respective communication behaviors, he or she can make more educated and strategic decisions when designing campaign strategies and messages for that public (Kim et al., 2008).

Finally, Grunig asserted that there are four kinds of publics based on their interaction with issues (Grunig, 1997). *All-issue publics* are publics who are active regarding all problems while *apathetic publics* do not give attention to any problems (Grunig, 1997). *Single-issue publics* are active regarding a small number of problems that affect a small group of the population like animal rights or local construction efforts (Grunig, 1997). *Hot-issue publics* are active regarding a small number of the problems that affect the majority of the population like political decisions and disease outbreaks (Grunig, 1997).

Risk communication scholarship. Risk is defined as any thing or situation that endangers a person or his or her values (McComas, 2010). Many communicators have a responsibility to consider their publics' concerns and find relevant and effective ways to educate them about managing their risks (McComas, 2010). An important concept in risk communication research is self-efficacy, which is a person's belief that they can complete necessary actions to make a change (Bandura, 1997). Communication campaigns can increase self-efficacy if they offer an explicit demonstration of how changes can be made (Bandura, 1997). However, since organizations often cannot make actual changes to constraints, an increase in self-efficacy is actually the result of an individual's changing perception of his or her constraints (Grunig, 1997).

In addition to constraint recognition, an individual's problem recognition and level of involvement also have this ability to change (Aldoory & Sha, 2007). Since communication behavior is based on these perceptions, it is important to understand the antecedent factors that affect problem recognition, constraint recognition and level of involvement, including the potential impact of cultural identity (Aldoory & Sha, 2007). Previous research has shown that racioethnic identity predicts problem recognition and level of involvement (Sha, 2006). Individual factors such as knowledge and motivation, as well as constraining factors like the ability to understand messages and familiarity with issues, have also been suggested as antecedents for the IVs (Sha & Lundy, 2005). Regarding cultural identity specifically, Aldoory (2001) studied factors that determine women's involvement with health messages, and found that source credibility, self-identity, and awareness of personal health and everyday experiences (i.e., motherhood, employment and living environment) were all antecedent factors for the IVs that could be used in message development for women from various cultural backgrounds.

Aldoory and Sha (2007) suggested that future research of the situational theory should continue to explore these antecedent factors, especially because many of the previous studies have examined all three IVs simultaneously. Since the foundation has been established and the relationships between the variables are understood, Aldoory and Sha (2007) suggested that future research focus solely on one variable at a time to provide a more in-depth articulation of each concept and strengthen the theory's framework and implementation.

While early research demonstrated cultural identity's potential impact on problem recognition and level of involvement, Aldoory and Sha (2007) identified a challenge in

measuring constraint recognition, which they deemed complex and evolving. This is because constraint recognition is dependent on multiple factors, including cultural identity, access to resources and the media environment. This means that an individual's ability to recognize her or his constraints is often based on their position in majority or minority cultural groups since the individual's experiences in those groups determine how she or he understands power. Further, if a particular group is not able to afford certain resources like proper healthcare, higher education, professional attire, and nutritional meals, or if they are discriminated against and are restricted in any other way from those resources, that group is more likely to feel constrained than a group which has access to and is often in control of these resources and more. Finally, a person's ability to obtain, comprehend, interpret, and apply messages distributed through various media is another determinant for how she or he understands constraints.

Cultural identity and access to resources and the media environment are all related to the study of Black women's interaction with health messages. Within this study, the situational theory of publics will be considered in relation to one culture's unique experiences.

Cultural Studies in Public Relations

Cultural identity is the identification with and understood acceptance into groups that share symbols, meanings, and social norms (Collier & Thomas, 1988). Intercultural communication scholars use the word culture to describe groups of people based on a variety of descriptors including, but not limited to race, ethnicity, gender, sexual orientation, and socioeconomic status (Sha, 2006). There are two relevant approaches to cultural identity scholarship for this research. The social psychological approach

considers cultural identity to be a personal characteristic based on interactions with society, while the communicative approach assumes that cultural identity is created through the exchange of messages, which require the negotiation, cocreation, reinforcement, and challenging of identity (Sha, 2006).

By studying cultures, communicators can discover the cultural meanings that publics assign to issues in the media, which are often affected by organizations and campaigns (Vardeman-Winter, 2014). Further, cultural studies have the potential to uncover valuable information regarding the impacts that public relations products such as messages, services, and community programs, have on society (Vardeman-Winter, 2014). These studies should be conducted with the explicit intention of causing social and environmental changes that affect marginalized publics (Vardeman-Winter, 2014). Such is the intention of this research to affect health messages targeting Black women.

Cultural identity as an antecedent. An individual's identification with certain cultural groups has the potential to predict the differences in his or her perceptions (Sha, 2006). For this study, I will only use the word culture to refer to race, ethnicity and gender within the United States. Race-based public relations research has used the situational theory of publics as a framework. The findings show that a public's understanding of race determines many of its members' communication behaviors since they have heightened problem recognition and personal involvement with racioethnic issues (Vardeman-Winter et al., 2013).

Cultural studies and the situational theory of publics. Heterogeneous societies are diverse groups composed of a variety of ethnicities, ages, genders, or other identities (Olofsson, 2011). Samovar and Porter (2003) defined the dominant culture within a

heterogenic society as the culture that most members of the society belong to and that is generally reflected in the mass media. These cultures contrast the recessive cultures, which are members of a society although they may not always be recognized (Samovar & Porter, 2003). Sha (2006) applied this idea at the individual level, writing that each person possesses dominant and recessive cultural identities, which become salient depending on the situation.

The majority of race-based public relations research has focused solely on the racial composition of practitioners (Kern-Foxworth et al., 1994; Pompper, 2005; Tindall, 2009). Sha's (2006) study of racial discrimination on college campuses was one of the first to consider race and ethnicity as theoretical components instead of the descriptive experiences of minorities in the field. The researcher surveyed a group of college students and found that those students who identified as non-White were more likely to recognize racioethnic problems, which supported the argument that racioethnic identity is significantly related to problem recognition and level of involvement. That study is one of the foundational studies for this research because the researcher explored the antecedents of the IVs and identified a relationship between race and perceptions. Further research surrounding the connection between cultural identity and the situational theory is necessary because it may produce useful insights about cultural identity's affects on constraint recognition specifically. For example, Tindall and Vardeman-Winter's (2011) research on women of color's experience with heart disease messages found that the shared constraints among the women included an inability to understand messages; lack of time, ability, or finances to make heart-healthy changes; distrust of information from doctors, and negative past experiences with medicine.

Gender and race are relevant to communication behavior, and communication scholars and practitioners developing campaigns should engage both identities at the same time in order to avoid telling partial stories when the identities are engaged separately (Vardeman-Winter et al., 2013). The intersection of these identities is very important to the study of Black women in order to better understand their unique experiences, specifically the way in which their experiences shape their decision making process.

Intersectionality Theory

Intersectionality theory asserts that social identities related to ethnicity, gender, sexual identity, class, and disability status are interdependent and create different understandings of unequal power distribution in society (Bowleg, 2008). Intersectional subordination, then, is often the result of one burden interacting with preexisting areas of vulnerability, which adds new depth to disempowerment (Crenshaw, 1991). Early scholars saw opportunities for research beyond the study of the individual social identities, and they began researching multiple identities simultaneously. This grew into the larger body of intersectionality research created by feminist and cultural scholars in multiple disciplines including philosophy, political science, and psychology, which made it an interdisciplinary theory and applied concept (Jordan-Zachery, 2012).

Public relations centers around understanding the identities of both the organization and the publics with whom the organization wishes to communicate. It is essential to consider the multiple identities of the publics' members in order to determine the individuals' perception of the organization and contribute to their communication behaviors (Vardeman-Winter et al., 2013). For example, Vardeman-Winter et al. (2013)

studied of a group of women's interaction with breast cancer-related health messages and found that if an organization does not consider the structural boundaries, which are connected to cultural identities and better understood through the intersectional theory, then the health issues will not be resolved.

Vardeman-Winter et al. (2013) incorporated three main characteristics of intersectionality in their public relations research. First, *identity interdependence*, establishes that all identities are dependent on one another and none exist alone without another (Weber, 2001). This means that a person cannot be only her or his race or gender, but is always the combination of the two. Second, *reliance on sociological othering* is based on a privileged group's reference to non-privileged groups as "other," making the difference between the two groups noticeable (Weber, 2001). It is important to recognize that the groups with the most power are referring to the groups with less power as the others, and that it does not go in the opposite direction, but is instead a demonstration of power distribution. Finally, *spatial and temporal contextuality* holds that all interactions are based on multiple identities so they should be reported as such (Weber, 2001). For example, in addition to the separate race and gender-based reports of HIV-infected persons, there should be a third report that combines the identities to just as easily understand how the disease affects Black women.

Gender and race, in addition to class and other identities, are systems of power that affect all of an individual's thought processes and social interactions (Vardeman-Winter & Tindall, 2010). Cultural scholars across disciplines must explore the complex meanings of all of these identities and their affects on the pivoting identity, which is the individual social identity that their research centers around such as gender for feminist

cultural studies (Luft, 2009). Additionally, in order to completely interpret and analyze a public's experiences, practitioners must rethink their own privilege and status, and recognize societal constraints and limitations such as access to resources and knowledge (Vardeman-Winter et al., 2013). This act is important for creating health messages because so much of the interpretation and reception of health information is based on an individual's health-related experiences.

Health public relations and segmenting publics

Health communicators have successfully used the situational theory to identify publics that they can target their health messages to (Aldoory & Sha, 2007). Still, with the changing global media environment, the cultural growth within the United States, and the variety of messages surrounding health and social norms, researchers have also identified noticeable gaps in conceptualizations that have traditionally been used in situational theory research (Aldoory & Sha, 2007). For example, publics are more likely to form around health messages that are negatively covered in the media and shared through other forms of communication than when it is positive (Grunig, 1997). This is because intense coverage of problems or issues can create a hot-issue public, which becomes active around a single problem that affects a large group of people (Grunig, 1997) like the global alarm surrounding the 2015 Ebola outbreak. In contrast, a campaign to share information that supports an organization's mission like the Leukemia Society's annual Light the Night walk, would only be acknowledged and processed by the organization's previously established active and possibly aware publics (Grunig, 1997).

Practitioners must be careful not to assume that a public's exposure to a campaign for or against a behavior will turn non-publics into publics since that shift would require

information processing, which is not guaranteed (Grunig, 1997). In fact, simply informing people about healthy and preventative behaviors, and convincing them to model such behaviors is usually unsuccessful in promoting sustained behaviors (Springston & Lariscy, 2010). These efforts are also limited when community stakeholders, health researchers and health officials fail to communicate and attempt to achieve different goals (Springston & Lariscy, 2010). The researchers found that intervention efforts made at the community level are more likely to achieve their goals than both individual efforts and efforts of state and national groups, who do not possess an understanding of local culture in the same way as a community organization. Applying Springston & Lariscy's (2010) observation to public relations, communication with a public (the community) is more likely to achieve an organization's goals than attempting to communicate with every individual person or with all stakeholders (state and national groups). Springston & Lariscy (2010) argued that each community possesses its own unique cultures, challenges and opportunities, which public relations practitioners can identify through research, then use to create strategic messages and programs. The intersectional approach is the consideration of these unique cultures, challenges and opportunities altogether as related factors.

Although the situational theory has been used in numerous public relations studies, only a small part of that research has considered health messages with women as key publics (Aldoory, 2001). An even smaller amount of that research has considered health messages and only Black women as key publics because the majority of research has looked at gender alone or race alone. Although this research recognizes the intersection

of these identities, the next two sections will overview Blacks in health public relations and women in health public relations based on the research to date.

The Black community and health public relations. Certain factors such as a lack of education, health insurance, and strategic advocates to fight for equality, make Blacks more susceptible to certain illnesses than Whites (Morris, 1998). These differences in morbidity and mortality based on race are called racial or health disparities. For example, data shows that Blacks are now 4.5 times more likely to die of medically preventable conditions than Whites (Morris, 1998). This disparity can be explained through the historical study of the Black community and health communication.

Wallace and Bartlett (2012) identified a noticeable difference in the recruitment and retention of Black and Hispanic girls and women as participants in research versus White girls and women. The lack of participation from Black people is often attributed to cultural mistrust of health care, misunderstanding and misinformation of research topics, inadequate recruitment efforts from researchers, stigma associated with specific topics, and racism among medical and healthcare professionals, but the trust issue is perhaps the most studied area regarding Blacks and health communication (Wallace & Bartlett, 2012). This mistrust has grown from previous experiments that took advantage of uneducated and poor Blacks such as in the infamous Tuskegee Syphilis Experiment (Wallace & Bartlett, 2012) and the dehumanization of Black women through health experiments that were unfit for White women (Feagin & Bennefield, 2014).

The Tuskegee Experiment, which took place over the span of 40 years, was designed and executed by the U.S. Public Health Service in an attempt to monitor untreated syphilis in Black men (Solomon, 1985). Research methods included blood tests,

physical exams, x-rays and autopsies, and the men were prevented from accessing treatment, which was developed prior to the start of the experiment in 1932 (Solomon, 1985). The men were given incentives of stipends and funds to cover their funeral costs, which they naively accepted as a kind offering while unknowingly agreeing to live out the effects of untreated syphilis such as blindness, insanity, and early death (Solomon, 1985). The ethical problems of this experiment motivated scholastic change as institutions created stricter research policies (Solomon, 1985). The experiment also affected social change as some members of the Black community were motivated to push for equality while others lost trust in doctors (Solomon, 1985).

Black women were specifically targeted in the 1939 Negro Project, which intended to reduce the Black population through eugenics (Feagin & Bennefield, 2014). This process included the testing of new birth control products on Black women, which contained high levels of hormones and increased the participants' risk of hypertension and stroke (Feagin & Bennefield, 2014). U.S. government officials also supported the forced sterilization of Black women and the project caused thousands of deaths during its existence (Feagin & Bennefield, 2014). In the case of Henrietta Lacks, a Black woman and cancer patient, her blood was taken without her or her family's knowledge in 1951, then mass-produced and distributed for profit after her death (Skloot, 2011). Lacks' cells helped discover the cure for the polio vaccine, while her family battled preventable illnesses because they lacked the funds for treatment, even after they finally learned of Lacks' contribution to science 20 years after doctors first took her cells (Skloot, 2011). Both experiments demonstrate systematic regulation of Black women's health and a lack of power over their own bodies.

While new policies protect human experiments on this level now, Feagin and Bennefield (2014) assert that the black-patient-as-inferior model is still being reinforced by medical institutions through the ignoring of black patients and the absence of systematic racism curriculum in historically White medical and public health schools. Health communicators should consider this history of Black people and traumatizing medical experiences before creating messages for this public.

Women and health public relations Hankivsky (2012) argued that gender-related health research generally centers around women and women's health. According to the U.S. Department of Labor (n.d.), women are now the primary health decision-makers for themselves and their families, and their unique health knowledge is relevant to the research of health messages constructed by media and campaign producers, (Vardeman-Winter, 2014). Considering this relevance, a few public relations researchers (Aldoory, 2001; Vardeman-Winter and Tindall, 2010, Vardeman-Winter, 2014) have conducted feminist cultural studies of women's health with the intention of understanding the ways that women perceive their health based on messages in the media (Vardeman-Winter, 2014). The findings from these cultural studies suggested that a woman's perception of her health is often the reflection of inaccurate media portrayals, and that it is not the norm or the acceptable standard for non-White, low-income women to see their multiple identities reflected in health media messages (Vardeman-Winter, 2014).

One example of this is found in Frisby's (2002) study of communication with Black women about breast cancer. The research showed that the participants desired advertisements that provided explicit details about causes and risks, and although they processed information from public relations campaigns, they were not motivated to

change their behavior and seek preventative screenings. Contextualizing these findings, the researcher suggested that future breast cancer-related communication should include Black women who were breast cancer survivors acting as role models for continued, healthy living (Frisby, 2002).

Aldoory (2001) also found that many of the health messages distributed through mass media do not accurately reflect the most threatening issues to women. For example, mass media health messages for women tend to focus on breast cancer and eating disorders, even though, according to the U.S. Bureau of the Census, heart disease was the primary cause of death for Black and White women in the United States in 1996 (Aldoory, 2001). This is not to say that health communicators have not attempted to produce accurate cultural campaigns, but the success of the campaigns have been limited. Aldoory (2001) found that women tend to base health decisions on their understanding of their health, self-identity, and everyday life. Women also determine the salience of messages based on all of their cultural identities (Sha, 2006), which influences their perceptions of problem recognition, constraint recognition, and level of involvement (Tindall & Vardeman-Winter, 2011).

Feminist research, conducted by women for women, is intended to expose differences in power in order to affect change and improve the experiences of marginalized groups through the investigation of missing, ignored, and avoided issues (Vardeman-Winter, 2014). Such is the case for this research in that the study of health messages with Black women as the key public is missing, ignored, and avoided. Vardeman-Winter's (2014) reflection of a previous study, which considered the media representations of, public health initiatives created for, and perceptions of girls and

women, called for more in-depth consideration of the researcher's interest in the topic, her reflexivity, and reactions to the findings. Tindall and Vardeman-Winter (2011) argue that feminist critiques are critical to the future of public relations and its ability to empower publics. This is especially true in this research, which takes a feminist approach, specifically a Black feminist approach, to challenge the hegemonic, or normal and natural, mass media health messages, in order to develop unique and effective ways to communicate with Black women (Collins, 2000). Black feminist scholarship has been greatly influenced by the historic suppression of Black women (Collins, 2000), yet a gap exists in situational theory research regarding antecedents of constraint recognition, which is directly related to this oppression. Constraint recognition is strongly affected by unequal power distribution, which is often recognized by those groups who have less power. Further, unequal power distribution shapes agency, which is the ability to act on or assert power (Crenshaw, 1991). Cultural groups with little to no agency are more likely to recognize more constraint. Black women are double minorities both because of race and gender, which means they are more likely to recognize constraints because of the unequal power distribution and agency.

In order to fill these gaps in the theory, researchers should extend the theory to account for the specific ways in which women receive, seek, and process information about health risks (Tindall & Vardeman-Winter, 2011). A few examples from Tindall and Vardeman-Winter's study were the women's understanding of their family medical history, conversations with doctors, and Internet searches.

Cultural identity and HIV communication. One of the most consistent suggestions for HIV health messages has been a cultural approach to encourage behavioral change

(Stephens, Braithwaite & Taylor, 1998). Lear (1995) suggested that in order for sex and HIV programs to effectively educate their target audiences, the messages should be consistent yet varied for everyone. In other words, the facts must stay the same, but the manner in which the facts are communicated should be uniquely crafted for each group based on their cultural identities. The researcher asserted that it is essential for the directors of health education programs to understand what the health problem means to the audience members specifically (1995).

One relevant, yet sometimes overlooked cultural identity for HIV communication is age. Young adults in particular are transitioning from adolescents to adults, and at varying times members of this age group may identify with both groups or with neither (Lear, 1995). This means that organizations must take unique approaches to communicating with this developing group concerning risk recognition and behavioral patterns (Lear, 1995). This group is worth researching because teenagers and young adults make up the highest population of sexually active unmarried people and tend to participate in serial, short-term relations that result in multiple sexual partners (Stephens et al., 1998). In steady relationships, this group uses condoms less frequently than outside of a relationship, and the perception of condoms as positive or negative often depends on the individual's confidence in using them, i.e. level of comfort, perceived effectiveness and implications of trust in relation to the sexual partner (Stephens et al., 1998).

HIV/AIDS messages and campaigns that place importance on cultural identity must address perceived powerlessness and promote the discussion of condom use and other risk reduction practices between partners, especially for Black women, who decide whether or not to use a condom based on their own personal factors (Stephens et al.,

1998). Another suggestion for effective campaigns with young adults in particular, is the use of friendship as an intervention strategy since friends are an important influence for predicting an individual's safe sex practices based on how and whether the friends communicated about sex (Lear, 1995).

Lear (1995) studied the manner in which risk and trust are socially constructed in relation to sexuality, both in general and as it deals with HIV in particular. The researcher found that the sexual communication, roles in negotiating for safer sex based on gender and sexual orientation, risk reduction strategies, and boundaries for safer sex all had an effect on the construction (1995).

Sexual communication introduces a new conflict within cultural identity related to HIV, first because a person's sexual identity does not always describe sexual behavior; for example, a large number of MSMs identify as heterosexual and maintain sexual relationships with women (Lear, 1995). A second conflict in sexual communication is that health communicators tend to use vague messages concerning safe sex practices in order to maintain trust with patients and to avoid alienating them, which may happen if health communicators imply that there is a normal standard of sexual relations, for example, recommending an acceptable number of sexual partners (Lear, 1995). A third cultural conflict related to sexual communication is gender. In the United States, stereotypical gender roles include the man's role as the initiator of sexual relations and the woman's role of determining the extent of sexual relations and enforcing or refusing the use of contraception (Lear, 1995). Not all sexual relationships reflect these stereotypes, so it is important to understand power distribution among sexual partners in order to better understand sexual negotiation between often unequal partners (Lear,

1995). Another gender-based conflict is the stigma for women possessing condoms. Some women feel that having a condom on them indicates the absence sexual innocence, demonstrates a masculine identity, and implies that she is actively seeking sex (Lear, 1995). Further, if the woman is seen as sexual, the women in the research believed that a man would consider her easy, fair game, and use her at his disposal (Lear, 1995).

For the most effective results, health communicators should consider all of these cultural identities and the places where they intersect when developing prevention programs. In consideration of urban youth and young adults in the United States, one unique tool for distributing HIV information has been the incorporation of hip hop as a communication strategy since this is a major part of many members of this group's cultural identity.

Hip hop and HIV Communication. Research has proven that hip hop music plays a significant role in urban Black youth's decision-making and behavioral patterns (Turner-Musa et al., 2008). The researchers defined the genre as a complex social structure expressed through not only music and dance, but also poetry, fashion, and film. Hip hop often reflects the shared experiences of underpowered groups, creating stronger trust with the audience and enabling them to feel personally involved with the content of the songs (Turner-Musa et al., 2008). For this reason, hip hop has generally been associated with Black and Hispanic urban youth, although in recent years, the genre has become more commercialized and adjusted to fit in "mainstream" culture (Turner-Musa et al., 2008) Historically, a large part of hip hop music has promoted negative stereotypes surrounding violence, theft, alcohol and drug use, sex, and demeaning portrayals of Black women (Collins, 2000; Turner-Musa et al., 2008), but research suggests that hip hop has

potential for health promotion and disease prevention because of its capacity for influence (Stephens et al., 1998; Turner-Musa et al., 2008).

The potential for hip hop as a tool for health message distribution has been limited by the mainstream culture's inability to appreciate all of its positive aspects (Turner-Musa et al., 2008), but the relationship has been studied within minority communities. Stephens et al. (1998) identified hip hop as an HIV prevention tool specific to the Black community's personal, social and community environment, and which has greater appeal than traditionally based interventions that are theoretical and target specific risk behaviors individually. The power of music as a tool for social development, and as an avenue for persuasive messages rests in its ability to engage listeners, its repeatability, and the opportunity it gives listeners to participate (Lemieux et al., 2006). The hypothesis is, then, that audiences who hear prevention messages through popular music, which offers stories of life experiences rather than explicitly stating ways to prevent HIV, will continue to listen to the songs in the future because of the songs' cultural popularity and radio presence (Stephens et al., 1998). The culturally relevant material of hip hop lyrics can be used to address a target public's health and educational needs (Stephens et al., 1998).

Lemieux et al. (2006) gathered local musicians who were popular opinion leaders and tasked them with creating hip hop music with HIV prevention messages that was then shared with hundreds of inner-city high school students enrolled in health classes within the same community. After evaluating the effectiveness of the messages on half the group who heard the music in comparison to the other half who did not, the findings suggested that when students are directly involved with the intervention, music-based

HIV prevention programs will have greater reception, be widely implemented, and be more effective. Although the results of this study did not provide a direct measure of music's strength, the researchers suggested that music may be a better intervention tool than other field-tested solutions because it is a major social influences for adolescents.

Turner-Musa et al. (2008) placed a group of middle school students, the majority of whom were Black youth, in a 10-week intervention program that used hip hop to teach prevention curriculum. In the program, students learned about alcohol and drug use, positive attitudes towards sex, relationship management, and HIV prevention strategies through interactive computer and group activities. The students completed a baseline survey on a number of issues including opinions of substance abuse and sex, and HIV knowledge, then completed the same survey six months later. The findings justified the implementation of this HIV prevention intervention and the research recommended further research on hip hop's ability to reach and teach young Blacks.

Research Questions

The purpose of the study is to better understand the connection between cultural identities and the situational theory of publics. Thus, the following Research Questions (RQs) guided data collection and analysis:

RQ1: What types of publics do Black women represent for HIV information-seeking?

RQ2: How do race and gender affect Black women's constraint recognition when considering mediated information about HIV/AIDS?

METHODS

Qualitative Approach

While quantitative research asks “how many” or “how much,” qualitative research answers the “what,” “how,” or “why” (Green & Thorogood, 2004). Qualitative methods include group or one-on-one interviews, in person or online participant observation, and paper or electronic document analysis, which provide open-ended responses that help to understand and explain a phenomenon (Tracy, 2013). This method is appropriate for participants that are not well understood or that have not been thoroughly investigated, such as this research’s consideration of antecedents of constraint recognition (Britten, 2011). Researchers use qualitative methods to study complex, sensitive, process-driven, and detail-oriented topics that require new and creative ideas, and can further be explored in secondary research using quantitative methods (Britten, 2011). This is because qualitative research not only provides detailed descriptions from the perspective of an involved party, but it also provides information for the development of conceptual definitions, typologies and classifications, explanations of phenomena, new ideas and theories, and associations between attitudes, behaviors, and experiences (Britten, 2011). Lear (1995) specifically recommended qualitative investigations in order to uncover information that can be used to create better responses to the risks related to sexual health issues, such as HIV prevention programs. Lear (1995) asserted that social research of AIDS had been traditionally based on quantitative research, but there was room for qualitative research as a predecessor for quantitative research.

Grunig (1997) asserted that the most difficult challenge for future research of the situational theory of publics would be to transfer it from academia to professional

practice. One practical method for this transition is audience-centered research using qualitative methods in order to understand a public's consumption process (Moffitt, 1992). This is something that Moffitt (1992) felt was a neglected area of public relations research. While not many researchers have conducted qualitative research to elaborate on the theory, the qualitative studies that have been conducted have effectively contributed to the body of public relations research (Aldoory & Sha, 2007).

The qualitative method is especially important for the study of Black women as it allows for the collection of data in the forms of communication that Black women traditionally adopted in order to express themselves in a White male-dominated society (Collins, 2000). These forms include casual and informal storytelling, literature, music, and everyday behaviors (Collins, 2000). The spatial and temporal complexity of intersectional research reflects reporting data in the same way that it is experienced in the real world, which was possible for this study through qualitative research.

In-Depth Interviewing

In-depth interviews empower respondents to share their perspectives subjectively using their experiences and viewpoints as references (Tracy, 2013). Interviews are especially useful for feminist research because they create an intimacy between the researcher and the participant, which is lost in survey research (DeVault & Gross, 2007). Because of lacking methodological literature in intersectional research, researchers interested in this approach have traditionally taught themselves and learned by trial and error (Bowleg, 2008). In addition to Sha's (2006) research on cultural identity as an antecedent to the situational theory's IVs, I modeled my study after Tindall and Vardeman-Winter's (2011) study of heart disease-related health messages with women of

color as the key public. The researchers' use of in-depth interviews allowed the participants to freely express their experiences, which demonstrated the spectrum of perceptions and proved that "women of color do not comprise a monolithic group in their meaning making of heart disease communication" (Tindell & Vardeman-Winter, 2011, p. 297). For this reason, I employed in-depth interviews to uncover Black women's meanings surrounding HIV/AIDS and the cultural factors that shape Black women's health decisions. The additional component to this research was that it represented Black women rather than all women of color, which increases the depth of cultural studies and public relations because it offers a unique understanding of Black women as a public for future segmentation.

Recruitment of Participants

After receiving institutional review board (IRB) approval, I intended to interview Black women who were 18 years and older and who attended one or more of the Hip Hop for HIV Awareness concerts. I located three women in the Houston area who attended the concert and were willing to speak with me. Although I knew five more women who attended the concert, I was not able to interview them because they relocated to other cities, which meant that in-person interviews were not possible. I reflected on my own personal experience – in 2007, I was 16 years old and an avid listener of 97.9, which meant I was in the target audience that year and every following year; however, I never attended a concert. For this reason, I also recruited twelve Black women who listened to 97.9 at the time of the concerts, but never attended one. I knew that this sample was a target public who at least heard the advertisements, so further investigation into their hesitations for attending the concert provided information for organizations who

communicate with Black women to better understand this group's interaction with health messages. The two samples differed in their concert attendance and this data was incorporated into the results for RQ1.

I conducted interviews until I reached saturation when the interviews provided support for the themes found in the previously completed interviews, rather than introducing new data. The justification of saturation is available in the remaining chapters. Since there were common themes regarding health understandings among both samples, the additional data that was unrelated to the concert motivations, hesitations, and experiences was considered together.

I used multiple strategies to recruit participants. First, I used *convenience sampling*, which is the employment of an easily accessible and inexpensive population (Tracy, 2013), to recruit volunteers from my personal network of college peers and members of my church who were Houston natives and 97.9 listeners. I contacted these women through informal phone contact and social media platforms Facebook and Twitter (Appendix A). Second, I used *snowball sampling*, where I asked participants who fit the study's criteria to recommend their colleagues, friends or family members who also fit the study's criteria (Tracy, 2013). This technique increased my sample size and provided a better chance of interviewing women with different experiences than my own, rather than the somewhat similar backgrounds that I have with women in my personal network. Finally, I used *typical instance sampling*, which focuses on the typical participant in a phenomenon (Tracy, 2013). The target audience for the concert was between 15 and 40 years old, so I only sought women who were between 15 and 40 years old at the time of the concerts since age is relevant to the understanding of the participants' information

processing. After receiving the participants' contact information, I emailed them the Participant Recruitment Letter (Appendix B) for more information.

Interview Guide

An interview guide helps the interviewer organize the discussion and identifies the main points for the interviewer to explore by grouping questions into a bank that the interviewer can use to ask the same question in different ways for different participants (Tracy, 2013). Intersectionality studies must include data collection instruments that uncover the participants' decision making process instead of the usual perceptions (Vardeman-Winter et al., 2013). Additionally, intersectional questions should ask about the participants' experiences without asking them to separate each identity (Bowleg, 2008).

I used two slightly different interview guides – one for participants who attended the concert (Appendix C) and one for those who listened to 97.9, but did not attend (Appendix D). These guides helped me establish myself as a listener rather than the primary speaker because of their flexibility as discussion stimulators, and gave some control of the discussion to the interviewee (Douglas, 1985). The guides also invoked responses marked by both content and emotion (Tracy, 2013), which is particularly relevant to the study of Black women, in order to better understand constraint recognition. Since in-depth interviews naturally convey which data are most important and interesting, the interview guides provided flexibility for future interviews based on the emerging topics (Tracy, 2013).

The guides for this study were framed first around the situational theory of publics, which explored the participants' current communication behavior surrounding

HIV/AIDS, as well as health decision-making factors based on the IVs. Questions exploring their upbringing and their perceptions of HIV based on their experience with 97.9 and the Hip Hop for HIV concert contributed to their demonstrations of the situational theory's DVs and IVs. Second, the interview guide employed the cultural studies approach, which explores cultural meaning-making concepts based on shared responses regarding symbols, relationships, and other cultural artifacts (Vardeman-Winter, 2014). Finally, it included suggestions from Jackson (2002), who recommended considerations for studying health research with women of color based on emerging models from women and gender studies, and race and ethnicity studies. I used the deep-structure form of cultural sensitivity, which Jackson (2002) recommended for understanding the health experiences of women of color. Deep-structure sensitivity incorporates group identification, history, geography and other social identities and inequalities in order to create strategies for providing the contexts for "perspectives, behaviors, and experiences that impair or mediate health outcomes" (Jackson, 2002, p. 562).

Also, when developing the questions, I used Ezzy (2010)'s suggestions for using qualitative research as an emotional experience in order to maintain the intimacy with the interviewee. I did not ask the participants for their socioeconomic status, but I did ask them to describe the household that they grew up in, which resulted in some shared socioeconomic information. Since this research centered around race and gender as antecedents of constraint recognition, I asked questions about the participants' perceptions of their own agency. An example of an agency-related question is, "*To what extent to do you feel like you have the necessary information and resources to maintain a*

healthy lifestyle?” Bowleg (2008) suggested that questions surrounding common and meaningful experiences should focus on stress and discrimination instead of simply asking about demographics, so I created the questions “*How did your household define the word health growing up?*” and “*What health issues do you consider to be most threatening to you?*”

Procedure

I interviewed five of the women at the location of their choices for their convenience and privacy because of the sensitivity of the topic, but I also maintained a list of easily accessible, quiet, safe and comfortable options for participants who did not have a preference (Tracy, 2013). These options included a vacant office at Fallbrook Church in north Houston, where I interviewed two participants, and the Starbucks closest to the interviewee's job or home, whichever was most convenient for them, and this is where I conducted eight interviews. I arrived at each of the sites early, and once each participant read and signed her Consent Form, I collected it and ask for permission to audio record the interview. I reminded the participant of my purpose for interviewing, the expected length of the interview, and the topics we would cover (Tracy, 2013). After the interview, I thanked the participant, answered any questions, and distributed HIV/AIDS information in the form of two handouts from the Texas Department of State Health Services: “African American Women and HIV in Texas” and “HIV/AIDS Among Blacks in Texas.” The intention for handing out these materials was to ensure that this research not only contributed to the body of public relations research, but that it also contributed to the communities to which the participants belong by providing basic information. Finally,

I asked each participant if she knew any other women who fit the criteria and may have been interested in participating.

Data Analysis

After each interview session, I typed my reactions to the interview in one comprehensive Microsoft Word document. I then transcribed the audio recordings in a separate Word document. At the beginning of each transcript, I included a summary with the participant's pseudonym, the length of the interview, and the date, time, and location of the interview (Rubin & Rubin, 2005). I used Glaser and Strauss' (1967) Grounded Theory, which means that I did not approach the data with preconceived notions of the answers to the research question; instead I collected the data and built the themes from the ground up (Tracy, 2013). As I completed each transcript, I printed the document and located initial codes by marking the text with notes and colored highlighters whenever the interviewee shared information related to her cultural identity and constraint recognition. I created a codebook in a third Word document based on my notes from each transcript. I used in vivo coding, which uses the participants' terminology, as often as possible in order to maintain the voice of the interviewees (Tracy, 2013). During this coding process, I used the constant comparative method to modify any codes in order to incorporate new data, which produced an accurate data set because of its adaptability (Tracy, 2013). After I completed this initial coding with all of the transcripts, I printed the codebook and once again, and used notes and colored highlighters to organize the data into themes and final codes. I then updated my electronic codebook with the final coding and used the emerging themes as an outline for the results section. Finally, in order to understand the data as intersectional research, I considered the responses in relation to the

sociohistorical reality of Black women in the United States (Bowleg, 2008). In reviewing the examination of power in feminist research, I recognized that my discernment in choosing which information is relevant, the decisions for coding, and the representation of the participants is an example of the researcher's power (Vardeman-Winter, 2014).

Validity and Reliability

Reliability is the consistency of the research, which includes the researcher, his or her research tools, and the method used for the study (Tracy, 2013). A reliable study can be reproduced in the exact same way by a different researcher (Tracy, 2013). Because of its qualitative approach, this study will produce different responses each time based on the lived experiences of the respondents and the researchers; however, the study can be reproduced to research other health issues with a marginalized group as the key public.

Validity is the research instrument's ability to measure the value of the research subject (Wolcott, 2001), and the ability or inability of the findings to be applied to the larger population from which the sample was generated (Lindlof & Taylor, 2012). The instrument included questions that encouraged the participants' to explicitly communicate their perceptions of health-related constraints. Since the women were recruited from different networks, I expected a variety of backgrounds that would exemplify the shared experiences of Black women across their other cultural identities. The different backgrounds are important for discovering as many constraints as possible. In this way, the results of this research demonstrated a pattern of constraints shared by the participants.

Reflexivity

Feminist research is driven by personal identity and experience; therefore, I had to convey self-reflexivity in the results of this study (Vardeman-Winter, 2014). I reflected on the recruitment process and my thoughts about interview responses in order to connect my identities and opinions with the larger issues (Tracy, 2013). I included an analysis of this autoethnographic research, which Vardeman-Winter suggested for future feminist-cultural research in an attempt to discover more feminist issues within public relations ethnography. Research is shaped by the researcher's background, values, and beliefs (Tracy, 2013), and although I am a Black woman who interviewed other Black women, I know that there is no singular narrative for this group, so I expected to hear and I did hear numerous experiences that differed from my own. Before interviewing, I began to consider the reasons why I did not attend the concert, and through the conversations, I had a better understanding, which is included in the conclusion of this work.

Participant Profiles – All names have been changed.

Name: Emery

Age: 29

Level of Education: Undergraduate Degree

Occupation: High School Teacher

Number of Children (if any): 0

Name: Tiffany

Age: 22

Level of Education: Undergraduate Degree

Occupation: Journalist

Number of Children (if any): 0

Name: Lauren

Age: 22

Level of Education: Some Graduate School (Master's Program, First Year)

Occupation: Waitress

Number of Children (if any): 0

Name: Sidney

Age: 28

Level of Education: Some Graduate School (Master's Program, First Year)

Occupation: Healthcare Account Representative

Number of Children (if any): 0

Name: Jamie

Age: 21

Level of Education: Some College (Senior)

Occupation: Full-time Student

Number of Children (if any): 0

Additional Comments: Pre-Med

Name: Vanessa

Age: 30

Level of Education: Undergraduate Degree

Occupation: Designer

Number of Children (if any): 0

Name: Angela

Age: 22

Level of Education: Undergraduate Degree

Occupation: Nurse

Number of Children (if any): 0

Name: Monica

Age: 24

Level of Education: Undergraduate Degree

Occupation: High School College Advisor

Number of Children (if any): 0

Name: Desiree

Age: 23

Level of Education: Undergraduate Degree

Occupation: Unemployed

Number of Children (if any): 0

Name: Mariah

Age: 25

Level of Education: Undergraduate Degree

Occupation: Human Resources Professional

Number of Children (if any): 0

Name: Kyra

Age: 22

Level of Education: Undergraduate Degree

Occupation: Personal Assistant
Number of Children (if any): 0
Additional Comments: Pre-Pharmacy

Name: Julienne
Age: 25
Level of Education: Undergraduate Degree
Occupation: High School Teacher
Number of Children (if any): 1
Additional Comments: Pre-Med

Name: Stephanie
Age: 21
Level of Education: Some College (Junior)
Occupation: Full-time Student
Number of Children (if any): 0

Name: Jennifer
Age: 21
Level of Education: Some College (Senior)
Occupation: Full-time Student
Number of Children (if any): 0

Name: Harmony
Age: 28
Level of Education: Undergraduate Degree
Occupation: Human Resources Professional
Number of Children (if any): 2

RESULTS

The 15 women who I spoke with discovered health information through a variety of resources, including doctors, websites such as Google, WebMD and social media platforms, television, school, older generations and personal networks. The two groups of women could be identified as aware and latent publics for HIV information-seeking, although both groups perceived the concert positively. The ways in which all of the women recognized their constraints for the consideration of HIV messages were based on a number of factors, including *mother-daughter relationships, competing health issues, silence in the Black community, religious beliefs, geographic location, and financial considerations.*

The participants were between 20 and 30 years old with an average age of 24. Twelve lived in Houston, two in Austin, and one in Washington, D.C. Twelve were single, two engaged, and one married. They shared similar levels of education as they were all college graduates except for two college seniors and one college junior. Five of the women currently work in or are pursuing degrees in the health field – I spoke with one nurse, one soon-to-be pharmacy student, two medical school hopefuls, and one health administration graduate who is currently working as an account representative at a Houston-area clinic. Other occupations included a journalist, a fashion designer, two Human Resource professionals, two high school teachers, one high school counselor, and a waitress.

Most of the women first learned of HIV in health classes in intermediate and middle school, and referenced the television shows and films that have most recently educated them about HIV, including *How to Get Away with Murder, Temptation, For*

Colored Girls and *Straight Outta Compton*. Every woman also expressed the benefit of preventative behaviors in health management, such as regular check ups and testing as a way to stay “ahead of the game,” keep an eye on things, and, if infected, immediately receive treatment in order to live longer.

RQ1: What types of publics do Black women represent for HIV information-seeking?

Types of Publics

Fourteen of the participants knew about the concert either from hearing it on the radio or from friends at school. Those who heard it on the radio agreed that the advertisements were hard to miss and constantly played on the station. “97.9 ran that like crazy. Like you heard it from Mad Hatter Morning Show to, um, what was it? DJ Michael Watts. You heard about that like all day on the radio,” said Sidney, 28, who attended the concert. The fifteenth participant, Vanessa, 30, said she had no idea about the concert and thought it may have been because they did not have the program when she was in high school, which was correct, she graduated before the first concert in 2007. However, as I described the process to her, she did recall advertisements for testing, but said she did not realize there was a concert.

Aware publics. Three of the participants attended the concert: Angela, the 22-year-old nurse; Sidney, the 28-year-old account representative; and Lauren, the 22-year-old waitress. All three women were solely motivated by the free concert with little to no interest in the testing process and HIV information. Sidney said, “It was the summer, I didn’t have anything to do. All my friends were going, I couldn’t buy the ticket, so might as well just go get the ticket for free.” They each said their lack of interest in getting

tested was because they were too young to understand the purpose or they were not sexually active. Sidney also said, "'Cause at that time I knew I didn't have HIV, like I wasn't do anything to have HIV, so I just went for the concert." None of the women had ever been tested before the concert.

Each of them remembered the artists who performed at the concerts and the long lines for both testing and the concert. Only Angela remembered the specifics of the distributed information at the testing site, the other two said they completely forgot. She said:

Now that I remember, I think when I went they did more than test you...they taught people how to like put on condoms or just different forms of contraception, so I thought that was really informative. Now that I remember.

Latent publics. As for the 11 who knew about the concert, but did not attend, hesitations ranged from anxiety of large crowds, to lacking access to the testing sites because of transportation or time restraints. Emery, 29, said she had "a preference of being around a certain population of people" and she "wouldn't wanna be around that environment of people." Several participants based the type of people who would attend the concert on the fan base of the artists, in Emery's case it was rapper Lil' Wayne. She thought, "This concert is going to get out of control, no one's going to be thinking about HIV."

While the majority of these participants were not interested because of the crowd, four of the 12 expressed that they wanted to go, Julianne, 25, even drove to one of the sites, but had to leave before she could get tested because the line was too long and she had somewhere to go. Jennifer, 22, said she and her sister did not find out the details in

enough time to go to the testing site. Desiree, 23, could not get to the testing sites during the time window, and Tiffany, 22, said, "I think it just wasn't convenient at the time 'cause I would've loved to see a free show."

Concert Perception

Two of the participants who attended the concert said that after attending the concert, they believed 97.9 created the campaign to encourage a change in behavior, specifically "to get people that normally would not get tested to get tested," as Sidney said. Angela did talk about one area of concern, "The process of the um, like actually getting tested wasn't that seamless. It was like, it kind of took a long time because a lot of people, I mean, I guess they had to keep it confidential." Beyond the actual time it took to get tested, Sidney appreciated the chosen testing method because of the associated anxiety:

I'm glad we had a rapid test because if they would have had to give me a call back, I probably would have cried the whole way home just thinking about life like, "Ugh!" And when you're younger, like even if you did have protected sex, I used to think I was pregnant all the time when I had sex.

Although the other 12 participants did not attend the concert, they still shared their opinions of the campaign. Emery said:

I think just bringing people in that were famous and all of that other stuff to kind of like – that was a good way to help them draw so that they could like be entertained, but also be...educated at the same time. And I think it's just a good way to keep that population of people informed and...uh, kind of on the up and up about what they need to know.

The others said the concert brought awareness to a targeted group without them being aware of the educational component. Jennifer said that because 97.9 is “so popular and everybody listens to them,” it was a smart strategy for the station to “make a program about teaching African Americans about something that they don’t talk about, which is like HIV and stuff like that.” This silence is further explored in RQ2.

RQ2: How do race and gender affect Black women’s constraint recognition when considering mediated information about HIV/AIDS?

Mother-Daughter Relationships

Ten of the women were raised in two-parent households with their mother and father, three of the women were raised in single-parent homes with only their mothers, and two of the women were raised in multiple households, rotating between their mother, grandmother and father and stepmother. No matter the household make up, every woman attributed her health perceptions and engagement with health resources to their mothers and/or grandmothers in some way or another. The women identified their mothers as the family member responsible for providing healthy food options, modeling proper health maintenance, sparking interest in the pursuit of health occupations, encouraging doctors’ visits, and managing personal networks for access to health advice. For these reasons, Tiffany said, “If you get the Black woman in the family, then I think you’ve gotten the Black community.” Many of the experiences that the participants shared concerning their mothers either demonstrated transparency about sex information or the comparison of their mothers’ health management to their fathers’ health management.

Transparency about sex information. Jennifer, who grew up in a single parent home, said that her mom taught her and her sister about sex when she was six years old because once they asked a question, their mom always gave them the “straight up” answer, and that is how she came to know about HIV and other STDs. Conversations about HIV between Julienne and her mother included unfiltered statements such as, “You better be careful...you gotta watch out...you could never get rid of it...you’re gonna die.” Lauren, who was raised solely by her mother, said that to this day, she openly talks to her mom about sex. Her mom, who is really involved with Lauren’s woman-specific health, always asks if she used protection. Lauren could tell that her mother wishes she was “less sexually active,” but said that as long as she is safe and uses protection, her mother does not care much. Kyra, 22, said that if she did contract HIV, her mom would be extremely upset, but she would not hate the participant and would offer her information about how to live a normal life with HIV.

Health and gender. When comparing women to men, most participants said that women take health more seriously, are more health-conscious, and are more adamant about getting tested than men, who are more “easy breezy” and usually think that they’re invincible. Monica, 24, said it depended on the individual because some women are very health-conscious and want to know everything. She compared these women to most men who think, “If I have it, then I have it.” Monica believed women either think, “I’m gonna open up and get help about it,” or they choose to remain silent. Beyond the decision to seek information, women are also more likely to take further actions. Julienne said that Black women specifically have, in many ways, pioneered the want to change and the drive to change. Monica said that Black women will let it be known if they are a survivor

and they are more intentional about giving back than men. This means that Black women are more likely to invest resources into helping other people who are dealing with health issues that they overcame or have learned to manage than Black men.

The majority opinion of women taking health more seriously was communicated in the comparison of mothers and fathers. Many participants reported that their mothers attempted to resolve health issues at home using home remedies, essential oils, and commonly, contacting people in the family's network, including doctors, nurses, people who have experience with the particular issue and older generations. When the issue could not be resolved at home, the mother was responsible for taking the participant to the doctor. It was suggested that this exposure to doctor's offices as children determined whether people feel comfortable seeking information from doctors as adults. In comparison, fathers were associated with being unconcerned about health, avoiding doctor's visits, and sneaking unhealthy food to the children when the mothers were not around. Kyra and her siblings joked that if they were only with their dad, they would not see a doctor until they were actually sick, meaning no regular visits for check ups and other preventative programs. Angela's dad even told her that rather than properly managing his health and adjusting his diet to meet the needs of his high blood pressure, he would rather just die happy.

Finally, there was evidence of the perpetuation of the mother's role as the family's health decision-maker for the next generation of mothers. Harmony, 28, who has two daughters, said she got a membership at the YMCA so that she could do something physically active with her children. She is also very conscious of the food that she

provides for her children, so she reads all food packaging and researches healthy food options.

The mother-daughter relationships, which were all composed of Black mothers and Black daughters, demonstrated the potential accessibility to health information and tools for the participants. While the mother's control of the family's access to health information could lower the women's constraint recognition, many of the women described their mothers as buffers or safety nets, which increased their constraints by hindering them from accessing information as adults. The participants also considered other factors such as competing health issues, when seeking HIV-related information.

Competing Health Issues

There was a clear difference in the women's HIV information-seeking versus other health issues. Although every woman recognized HIV as an issue, the women did not perceive it to be as threatening as other health issues that are more closely related to their lifestyles. These competing health issues included cancer, high blood pressure, high cholesterol, diabetes, obesity, heart disease, yeast infections, arthritis, Alzheimer's, sinus infections, anxiety, eczema, and headaches. These issues were seen as threatening because they are most often associated with the Black community or they ran in the participants' families, which meant that most of the women had witnessed the effects of one or more of these issues on their loved ones. Emery was the only participant who had a personal connection to HIV because her aunt and uncle were HIV positive and died from AIDS related illnesses when she was younger. The disconnect between the rest of the women and the disease was articulated by Tiffany, who said, "I don't know that many people, if anyone, that's been affected with HIV." Sidney argued that a health issue is not

seen as a threat to Black people until something drastic happens. “The Black community does not [seek information] until you see Big Momma pass away like, ‘Oh, let me go check up too,’” she said. Although the perceived threat level is low, the women did acknowledge the promotion of HIV information in the media, which Tiffany suggested was because HIV treatment is expensive and “that’s why people promote HIV so high versus heart disease or cancer ‘cause...heart disease is very affordable.” The other participants commented on the difference between today’s HIV promotion and earlier messages.

Shift in HIV Communication. Most of the women said they do not see HIV in the media as much as they did when they were growing up, and when they do, it seems far less life-threatening. “I always see billboards promoting getting tested in a positive way and I love that,” Emery said. This is in comparison to when many of the women first came to know about the virus and saw it as a scary, death sentence that was discussed more in the media. Tiffany said:

I think I came after the era where it was like a death sentence, so now it's kind of like yeah, it's bad, but it's like, “Okay, you have HIV, it's not the end of the world,” kind of like now what? Like, “Here's the precautions you take, here's the medicine, you'll live a normal, healthy life like everyone else.”

The shift in the communication from a negative light to a positive light has affected some people's perceived level of threat. Tiffany also said:

It's still a big idea, but I think it's kind of been, since it's so much in the media now and talked about more openly, it's kind of desensitized and the fact of – like to me, it's still not as devastating as a disease as I would say like cancer.

Preoccupation with competing health issues that are mostly determined by the diseases commonly present in the Black community, acted as a constraint for the women. This priority of issue deterred women from seeking information about HIV, and the disinterest in research was reinforced by the silence in the Black community.

Silence in the Black Community

HIV was described as “that thing in the room that nobody really wants to talk about” because of the negative publicity and stigma connected to the disease and those who contract it. Although most of the women pointed out that HIV is no longer seen as a death sentence, Kyra said, “When you hear HIV, you automatically think death,” or you assume “you’re gonna die within months or you’re gonna die within years.” Tiffany said no one wants to talk about it because none of their family and friends are affected by it.

The women also attributed the silence to judgment that is traditionally present in the Black community. Monica said members of the Black community may take the proper steps to take care of themselves, such as check ups, research, vaccinations, and medical treatment, but they won’t let anyone know. The reason for this is fear of judgment because of the risky lifestyles that are most often associated with certain diseases. “I think that as African Americans, we are very – we can be close-minded, I mean, we may go take care of ourselves, but we won’t let anyone know, and I think that can be a big factor,” Monica said. She suggested that this is especially negative for the Black community because their experience could benefit the other members’ health knowledge.

Other women said that even though someone may know something is wrong with them, they are likely to keep it to themselves if they feel unsure about who they can be

open and comfortable with. They may wonder, "Who do I go to?" While one participant communicated that she had a reasonable number of family and friends, she said that she does not have many friends who she would honestly ask, "What's wrong with this?" when trying to understand a health issue. It was also suggested that the biggest constraint for why Black people do not get tested is because they are too concerned with what people will think about them if they seek information about HIV.

Although there is silence in the larger Black community, several of the women shared that they do engage in conversations about HIV with their sexual partners. While Sidney said that she talked to men about their HIV status, but she did not require a test, Lauren said that she warned men that they would not be doing anything sexual until he took one of the \$50 over-the-counter HIV tests, which she said he should be able to afford.

This silence increased the women's constraint and lessened the likelihood of them learning about HIV through everyday conversations. In addition to silence in the Black community, religious beliefs were another race-based factor that affected constraints.

Religious Beliefs

In the conversation of health, every woman made at least one reference to her Christian faith. Two women grew up with pastors as parents, and Angela, who said she was born and raised in the church, said that different organizations in the church such as health ministries, offer valuable and easily accessible information for its members. Mariah, 25, learned about essential oils from a woman at her church and has been looking more into it. I asked Monica, who felt strongly about the silence in the Black community, about her recent interaction with HIV communication. She replied:

The only time I've actually really seen anything about it is if I'm at a church...and then they're like, "Hey, we have this organization that's working with us and we have this [HIV awareness] walk."

Vanessa said that the reason our community is faced with a growing number of health issues is because of the manipulation of things created by God. "I feel like we're kind of duped into believing we need all these extra things...if you just keep it simple, and not add more into a lot of, I guess, God-made things, things that are naturally made in the Earth, we probably wouldn't be as sick as we are now," she said. Stephanie, 21, said that she is motivated to care for her body because it is a "temple of God," according to Christian beliefs.

Several women felt that their health is not completely in their control and they rely on God to remain healthy. Tiffany said, "Cancer runs in my family, so the only thing I can – I mean you can't really do anything about that, but pray." When speaking of her own health management, Vanessa said, "It takes time and you just have to be diligent and disciplined and also like personally, I just pray about a lot of it." Kyra even said that contracting the virus does not necessarily mean the prayer was unanswered: "Maybe it's in God's will for you to do this...maybe God wants you to go be a spokesperson."

The women's religious beliefs, which is often influenced by race and has historically played a role in major community movements led by the Black community, affected their interaction with mediated information about HIV/AIDS. It increased their constraint recognition because their trust is in God to take care of them meant less of a responsibility to manage. so did their geographic location, which can also be determined by race and the decision to live in areas with families from similar backgrounds.

Geographic Location

Many women felt that their access to information was determined by their geographic location and the issues that the message creators in that area chose to address. Emery said that she would never see an HIV awareness billboard in one of the predominantly-white Houston suburbs, but she is much more likely to see one in the minority communities across town. Jamie, 21, said that she was not exposed to information about HIV growing up and suspected that it may have been because the residents in the area where she lived, which was predominantly white, may not have thought it was serious enough to communicate about. Vanessa, who spent time in Chicago and New York, said she saw HIV messages a lot in those areas, but she does not see them as much in Texas.

The geographic location increased the level of constraint since they could not access information that was not provided. The participants suggested that areas with higher minority populations were more exposed to HIV messages, but had more complicated access to health resources, which was affected by financial considerations.

Financial Considerations

In the conversation of health management, every woman talked about her experience with doctors. We discussed insurance in more than half of the conversations, as this was often a motivating or restricting factor for visiting the doctor. Jamie, whose parents preferred to treat her with natural remedies, said that the only reason they took her to the doctor was because they had insurance, "Like we're paying for it, let's get you a check up." She added that her insurance is also the sole reason why she visits the doctor as an adult.

Overall, the women agreed that health insurance is not always as accessible for Black people. When asked what was unique about how Black women see HIV versus other groups, Monica said, "Most Caucasians are usually able to have those financial resources or someone to help provide for medicine versus in African American culture, you may not have the insurance as other means to pay for that." The lack of insurance keeps a large group of people from seeking medical attention at all, according to Sidney:

When I was a kid, I used to think a trip to the hospital was, you know, \$100,000, which it is...but, you know, it's cheaper to just have your insurance and most people do not have insurance. Once, myself, once I got off my mom's insurance, that was it. I just got it 'cause I got a job that offered it, but some people are like, "Oh, I'm not going to pay for that insurance." That's mainly the reason why I think most people in the African American community, they don't have healthcare, so they just figure, "I don't have it, I'm not gonna pay out of pocket for that."

Lauren, who visited a free clinic every three months to get tested because she did not have health insurance, said, "It's really easy to get free check ups for your women stuff" in Houston compared to other places. For other purposes, she said the free clinic was her last resort. "I'm looking up home remedies, I'm trying my best to not spend a whole bunch of money 'cause I don't have a way to pay it besides out of pocket," she said. The inability to cover the costs of medical expenses not only increased constraints and affected the Black community's sense of urgency for visiting the doctor, but also their interpretation of accessibility to more serious resources such as HIV treatment.

Familiarity with Magic Johnson's HIV Status. Every woman referenced Magic Johnson at least once during her interview. Many of them connected him to the first thing they learned about HIV, although the only thing that most of them understood at the time was that the basketball league did not want him to play. Although Magic Johnson is Black, the women considered other factors, specifically his financial resources, that separated him from the rest of the Black community. Kira said, "You can't really manage HIV unless you're rich and have all that money like Magic Johnson." Angela said she thought, "Oh, Magic Johnson, he has it, but he doesn't have it," and wondered if it was because of his money and other resources that normal people do not have, or if maybe, the normal people just were not compliant to the heavy drug regimen that is required of HIV positive people.

Although most of the women addressed the difference between Magic Johnson's experience and the average person's experience, Magic Johnson's activism regarding his own status also provided access to HIV information for Desiree. As a recipient of the Magic Johnson scholarship, she traveled to California each summer during college to spend a week with him and other scholarship recipients. She first learned about HIV during her first trip when two HIV positive people talked to the students about their experiences:

One got it from like sexual stuff and the other guy got it through a needle and like, he didn't know about it until he was like throwing up blood and he went to the doctor and they had no clue, he had no clue like that was the reason," she said. so I didn't learn until late and when I learned, it was more so of...a scary moment.

The experience made Desiree want to take care of herself. "I'm not gonna lie, I think this way, I'm like, "It's me, how could that happen to me?" I'm like a good person, at least I would think ...but I think it takes one moment," she said.

The Black community's understanding of Magic Johnson's status demonstrated that it is possible to live with the disease, for those who do believe he is infected; however, it is the most explicit demonstration of the need to have financial resources in order to properly manage HIV. Their familiarity with his status and experience increased their constraint recognition.

DISCUSSION & CONCLUSION

I used qualitative methods to investigate the ways in which race and gender affect Black women's constraint recognition when considering mediated information about HIV/AIDS. Fifteen Black women were interviewed individually to better understand their perceptions of health and their health decision-making processes. Almost all of the participants said they had the information and resources – or they knew how to locate the information and resources – to remain HIV negative. However, several participants admitted to relying on outdated statistics or statistics that they did not trust, or not knowing any statistics at all. They saw no urgency in exhausting their resources and monitoring the disease, which has prevented this group of women from considering HIV-related information. As Angela asked, the question remains, “Why don't you do what you're supposed to do if you know you're supposed to do that?” Meaning that one woman said she wished Black people were more educated about HIV, another said she thought she should know more about it, and several others said they should make better use of their resources, yet none of the women sought information or engaged in conversations about HIV, outside of sexual partners. “I feel like I do have access to resources, but I also do feel like I don't use my resources as I should,” Kyra said. Based on the results of this study, the Black women's constraints can be attributed to mother-daughter relationships, competing health issues, silence in the Black community, religious beliefs, geographic location, and financial considerations.

The study required an intersectional approach in order to gather data for this unique population who are both women and Black. Other factors may have also been considered in order to better understand the intersectionality of a group's cultural

identities, including socioeconomic status, sexuality, and education level. Although the women were not specifically asked for their socioeconomic status, many of them provided this information when describing the households where they grew up.

Unfortunately, there was not enough data to demonstrate a relationship between the participants' socioeconomic status and their constraint recognition. Sexuality was another factor that was not formally discussed, except for the married and engaged participants, and those who shared the conversations they had with their sexual partners. All of the women shared similar levels of education.

Theoretical Implications

Situational Theory of Publics. The situational theory of publics provided a strong foundation for understanding how it was possible to get similar responses from participants from different backgrounds who have no social connections to each other. According to Grunig (1997), a public shares public opinions that are shaped by personal understandings of past conversations and experiences. The positive role of the participants' mothers in the way that they came to know health and the repeated references to religion and Magic Johnson demonstrated a shared understanding at least among Black women in Houston who are in their 20's and 30's.

Where Grunig (1997) suggested that the situational theory of publics may be used to predict when an activist group may form, the results of this study demonstrated an opportunity for an organization to better understand Black women as a public. This will allow the organization to communicate information about HIV/AIDS in a way that will motivate them to come together and make decisions and perform actions that can help the organization achieve its mission.

Almost all of the women in this study demonstrated the use of passive communication because they unintentionally received messages about HIV/AIDS, rather than seeking the information, or in this study, attending the concert. Overall, the women demonstrated high problem recognition and medium to low level of involvement because many of them had no personal connection to the virus. Constraint recognition, which was the center of this research, was a little more complicated to understand. While the women said they had access to the information, certain factors constrained their engagement with mediated information about HIV/AIDS.

Aldoory (2001) determined women's seeking of health messages as it relates to problem recognition, constraint recognition and level of involvement, which included source credibility, self-identity, and awareness of personal health and everyday experiences. Similar findings were present in the responses of the participants, so this research supported the use of these factors for message development. In particular, the competing health issues were reflective of the women's everyday experiences as they witnessed parents, grandparents, aunts, and uncles manage, and unfortunately, in some cases, succumb to certain diseases.

This study centered solely on constraint recognition because Aldoory and Sha (2007) suggested that future situational theory of public research should focus on one variable at a time. While I see the benefit of this process, I believe that the interviews I conducted also provided beneficial information to better understand Black women's problem recognition and level of involvement as it relates to general health, but that data cannot be considered in the context of this research. The researchers said the study of constraint recognition is challenging because it is complex and evolving based on a

number of factors. While I did interview women who are minorities because of both race and gender, they all had access to higher educations and nutritional meals, which Aldoory and Sha (2007) suggested will enable a group to feel less constrained. The women who I spoke with did demonstrate low constraint recognition in terms of accessing information via the internet and doctor's visits. However, their unique experiences, specifically their skewed perceptions of health threats based on traditional diseases and their reliance on God for health prevention introduced new responsibilities for organizations to sensitively communicate HIV information to Black women. These organizations must find a balance between communicating the risk in comparison to the other diseases without invoking fear or making the other diseases seem less threatening as the women have relationships with sufferers of these health issues. The organizations must also find a way to persuade the women to take control of preventing infection while respecting both the religious opinions of sexual activity and the women's trust in God's absolute control over every situation. These factors must be incorporated into communication in order for women to recognize the need and feel empowered to seek information.

Cultural studies in public relations. The data supported the claim by Vardeman-Winter (2014) that communicators can better understand the assigned meanings that cultural groups give to issues in the media by studying cultures. For example, because the women understood Magic Johnson different from an average Black person living with HIV, an organization that was seeking to inform Black women about HIV may choose to use an unknown spokesperson instead of Magic Johnson so that they will consider the person relatable.

Similar to Sha's (2006) study, this race-based study also demonstrated a relationship between race and perception specifically as it relates to the women's perception of threatening health issues based on diseases that plague the Black community. In the discussion of perceptions of HIV, some of the participants had difficulty breaking down the perceptions of women versus Black people because they understand life as Black women without being able to separate the two. "It's hard to make a separation in like any instance between...like just being a woman. I'll always answer it as being a Black person," Tiffany said. This supported Vardeman-Winter et al.'s (2013) suggestion for campaign developers to engage both gender and race simultaneously.

Health public relations and segmenting publics. Grunig (1997) suggested that there is a higher chance for publics to form around negatively-covered health messages than positively-covered health messages. Based on this concept, the shift in the perception of HIV from negative to positive decreased the chance for publics to form around HIV messages, which was conveyed in the data. Now that Black women understand that the disease is preventable and treatable, Lauren said, "I don't think people are as worried as they probably were initially, like when they thought it was just a gay person's disease."

Grunig (1997) also advised practitioners not to assume that a campaign will turn a non-public into a public because information processing is not guaranteed. Such was the case with the three women who attended the concert. Springston & Lariscy (2010) suggested that providing basic information about healthy and preventative behavior and

telling publics to mimic it is usually not successful for promoting sustained behaviors, which describes the condom demonstration that only Angela remembered.

Springston & Lariscy (2010) also suggested that intervention efforts at the community level are often more effective, which could be considered true of 97.9's Hip Hop for HIV Awareness concert. The concerts drew large crowds and resulted in the testing of thousands of teenagers and young adults. Additionally, the radio station had and continues to have a positive reputation with the women I interviewed because of the station's community engagement, not just as it relates to HIV, but also to other issues that matter in the community such as voting, health awareness walks, and fundraisers. The women had established relationships with the station from everyday listening and Tiffany said, "They might not know me personally, but they still feel like Johnny from down the street or something."

Although the focus of this study was on Black women, the data about the Black community and certain subgroups' unique relationships with doctors supports Morris' (1998) statistics about the number of Blacks who are likely to die from preventable conditions. Surprisingly, most of the responses I heard about hesitations for visiting the doctor were not because of distrust as the literature previously suggested, but rather because of financial considerations. This factor was influenced mostly by race, while mother-daughter experiences confirmed statistics regarding gender in the U.S.

The importance of the women's mothers in health-related decisions and conversations was reflective of the U.S. Department of Labor's (n.d.) identification of women as the primary health-decision makers for themselves and their families. This

evidence of women's roles in health management should be considered when shaping health messages, specifically as it relates to representation.

Vardeman-Winter (2014) found that it is not the norm for non-White, low-income women to see themselves represented in health messages, which I would say was another success of the concert since the majority of the women said they immediately felt targeted by the station when they heard and saw the advertisements geared toward young, urban, minority teens.

Women and health public relations. In the consideration of this study as feminist research, this study now contributes to the small number of studies that has considered health messages with Black women as key publics. This data is important because as the country increases in diversity, organizations need to improve their communication with minorities. The Black community faces health disparities in suffering from certain diseases, which makes them more deserving of attention during health campaign development (Tindall & Vardeman-Winter, 2011). Women have become the major health decision-makers for their households. Black women are expected to be silent about certain issues in the Black community, yet activists among other women who are experiencing similar health issues. Their experiences are "situated within multiple, intersecting institutional oppressions and opportunities," according to Tindall & Vardeman-Winter (2011), and health communicators must keep that in mind when communicating with this group and other marginalized populations (p. 299). Beyond race and gender, our nation is exposed to new outbreaks every year. These previously unknown diseases met with access to new treatments, increased travel, and increasing political participation in medicine, means that health communicators must work harder to

quickly distribute easy-to-understand information crafted specifically for each of the affected publics and within the context of other health issues. By learning more about Black women as a public, these health communicators will also have more information for communicating with Black people and with women.

Reflexivity and feminist research. In keeping with the reflexivity encouraged by Vardeman-Winter (2014) for future feminist research, I considered my thoughts as a Black woman speaking with Black women about issues that affect Black people. I thoroughly enjoyed each of the conversations and the way they felt very casual like I was talking to my sister-in-law or best friend. I quickly learned to stop myself from agreeing with the women too soon so that I would not cut them off from expressing their thoughts just because I knew exactly what they were talking about. I did not realize how much laughter I shared with the women until transcription, and after reading the transcripts all together, I noticed how much the participants and I used slang, most popularly “cause” instead of “because,” and traditional Black sayings, which included phrases like, “Ain’t nobody got time for doctors....We are not about that life....Black don’t crack....We really don’t fool with it.” This was perhaps my favorite discovery because it showed the women’s comfort with speaking to me, and I recognized that they probably would not have used those phrases with a non-Black researcher. Even if they did use the phrases, I wonder if a non-Black researcher would have been able to understand the cultural meanings of the phrases.

I must also note the effect that my research (not just the content) had on the women I interviewed. Tiffany sent me a text after her interview saying that the night of our interview, she started researching graduate programs for herself. Desiree contacted

me every week after her interview wanting to know how the rest of my collection went and the writing process and information about the defense process. Jennifer expressed how inspired she was by how my research related to our community, and how she hopes she will be able to do the same in her field when she attends graduate school.

The positive feelings were not limited to those people who I interviewed, one sorority sister who was born and raised in Dallas, which means she could not be interviewed, connected me with two of her coworkers who I interviewed and she was genuinely excited to have contributed to my research. Additionally, my Facebook recruitment post was shared by 12 people, none of whom met the criteria for my research, but again, wanted to contribute to the research. Finally, one of the most rewarding parts of the interviews was distributing the handouts at end. I found that many of the women felt discouraged by their lack of knowledge about HIV even though they recognized it as a problem, so providing them with a brief summary of the relationship between HIV and Black women in Texas filled the void since they probably still were not completely motivated to look into it on their own.

One question that I had during the interview process was whether or not to correct the women about false statements about HIV. Examples of this include one of the participants' suggestion that heart disease management is inexpensive and another participant who did not think many Black women were affected by the disease. On one occasion, I did provide corrected information about HIV positive women birthing HIV negative children, but for the rest of the interviews, I waited until I gave the participant her handouts to clarify any rumors. I was hesitant to correct the women because I wanted to hear their responses based on their thoughts prior to speaking with me. Like

Vardeman-Winter (2014), I did not want the corrections to “contaminate the research process” (p. 102). However, the researcher referenced Naples (2003), who clarified that feminist research is intended to enable research participants to empower themselves with the end goal of being informed and able to make her own decisions. While the distribution of HIV material supported this understanding of feminist research, I could have taken advantage of the opportunity to educate the participants during the interview.

Cultural identity and HIV communication. Lear (1995) suggested that organizations must use a special approach for communicating with young adults. To my surprise, age was a factor that came up in almost every interview, whether the participant was in her early 30's and picking up new physical activities to better manage her health or whether she was in her early 20's feeling invincible. The participants' use of their age to voluntarily identify themselves reinforced the idea that this is an identity that should be taken more into consideration when developing campaigns. Lear (1995) also suggested that friends be included in campaign development because they tend to influence an individual's safe sex practices, which was also supported by the data. While some of the women initially heard about the concert through the radio, the rest of the women found out about it through friends. The three women who went to the concert each went to get tested with friends. Beyond the concert, Lauren said that when her friends share stories with her, she will address them if she suspects that they did not use protection.

Practical Implications

Grunig and Ipes (1983) suggested that campaigns communicate step-by-step instructions for publics to lessen the constraints that prevent them from creating change. In this case, an HIV campaign geared toward Black women should offer steps to make

their own decisions; understand HIV in comparison to other health issues; speak up in the Black community; understand HIV in a religious context; discover the specific effects of HIV/AIDS in their areas, and how to communicate those effects to the people who can make changes in communication; and access resources that could preserve an HIV positive person's life.

Limitations of Study

The largest limitation of this study was the recruitment of participants. Because of resource limitations, I was able to connect with very few Houston residents who attended the concert and still live in Houston – I had two sorority sisters in my personal network who attended the concert and one of them also connected me with one of her friends. I also considered that I may have had access to more participants if the concert was still going on. In fact, many of the participants who did not attend wanted information for this summer and I had to inform them that the station no longer hosts the concert.

Another limitation was the similarities among the women who I interviewed. In addition to all of them having experience at 4-year universities, 10 of the women grew up in households with both parents, the majority incorporated Christianity into their interviews, and only one person disclosed that she was uninsured. Additionally, one-third of the women I spoke with are in the health field or are looking to enter to the health field, so they had an increased interest in seeking health information and greater access to health messages. All of the participants came from fairly high socioeconomic statuses and did not reflect the subgroup of Black women experiencing the HIV epidemic, who are often poor and uneducated. The study would have produced different results concerning constraint recognition if I was able to speak with Black women who do not

have college educations; did not grow up with both parents in the home, specifically women who were raised primarily by a man instead of a woman; who are not Christian; and who are not insured through their jobs or their parents' jobs. Since each of those are sensitive traits, it is not possible to recruit the women in those specific categories. I do believe that the reason for the similarities among the participants is because of my own personal network. I am a college-educated Black woman who grew up with both parents in my household, I am a Christian, and I am insured through my dad's employer. As several of the participants shared, I am also surrounded by like-minded people and with the exception of more than half of my friends being raised in single-parent homes, the Black women in my network, tend to share those same identities with me.

Future Research

Because there has been little research of Black women as a key public for health communication, future research should study Black women's problem recognition, constraint recognition, and level of involvement simultaneously like traditional situational theory of publics research, instead of focusing on just one variable like I did in this study. This research should first be conducted using qualitative methods, but with the intention of using the collected data to design a study that would use quantitative methods. The quantitative research will be useful for collecting data from a larger sample size and could also be used to compare Black women to other cultural groups based on responses.

I also recommend future research that still considers Black women as the key public, but that uses a focus group rather than one-on-one interviews. For one, some women feel more secure when they hear other women who have similar experiences as they do. Specifically in regards to Black feminist research, it provides more opportunities

for casual storytelling since one person's story may spark another person's memory about a related event. Finally, since silence in the Black community was a major theme in the interviews, this could be one way to get the conversation going and encourage them to share what they learn with members of their respective community.

Additionally, as it relates to the Black community and health public relations, I recommend further research into the Black community's medical mistrust, which may be primarily present among older Blacks. I would suggest an investigation of Black men and women and their perceptions of health as well as their sources of health-related information.

Appendix A: Social Media Recruitment

Facebook

As many of you know, I am a second-year public relations student in the graduate communication program at the University of Houston. I am currently recruiting participants for my thesis project surrounding cultural identities and interaction with health messages. If you or someone you know is a Black woman who attended one or more of 97.9's Hip Hop for HIV Awareness concerts, and would be interested in sitting down for an interview with me, please send me your email address in a private message, and I'll send you more information about my research. Participants must be 18 years or older. Thank you in advance for your support! This project has been reviewed by the University of Houston Committee for the Protection of Human Subjects (713) 743-9204.

Twitter

Tweet 1: I'm recruiting participants for my thesis project surrounding cultural identities and interaction with health messages. (120 characters)

Tweet 2: If you/someone you know is a Black woman who attended at least 1 of 97.9's Hip Hop for HIV concerts and would be interested in interviewing with me, (149 characters)

Tweet 3: please DM me your email address and I'll send you more info. Participants must be 18 years or older. Thanks in advance for your support! (137 characters)

Tweet 4: This project has been reviewed by the University of Houston Committee for the Protection of Human Subjects (713) 743-9204. (122 characters)

Appendix B: Recruitment Letter for Participants

Once potential participants have been identified, the following email will be sent to them individually:

Subject: Information for Interview with Jasmine Powell, UH Graduate Student

Ms./Mrs. _____,

My name is Jasmine Chanel Powell, and I am a graduate student in the Jack J. Valenti School of Communication at the University of Houston. I am contacting you in hopes that you may be interested in participating in a communication study for my thesis project.

I am conducting one-on-one interviews to explore how culture affects health decisions, specifically among Black women who attended one or more of 97.9's Hip Hop for HIV concerts. If you are interested, the interview will last approximately an hour, and all of your responses be kept confidential. There are no right or wrong answers – any information you can provide will be helpful! Your participation will help understand how Black women learn about health and how they make their health decisions.

We can meet at a location convenient for you, such as your office or a local coffee shop. When we meet, I will provide you with a form stating the details of the report and who you can contact with any questions. I will also ask that you sign a form granting me permission to audiotape our interview for accuracy purposes. I will be the only person to listen to the audio recordings and know your real name.

Thank you very much for your consideration, please contact me if you are interested in participating or have any questions for me.

Thank you,

Jasmine Chanel Powell

This project has been reviewed and approved by the University of Houston Committees for the Protection of Human Subjects (713)743-9240.

Appendix C: Interview Guide for Individual Interviews (Concert Attendees)

Each major question is followed by the theoretical construct that the question is exploring in parenthesis.

Thank you for talking with me today. Before we begin, could you please read and review this consent form concerning your participation today. If you have any questions, just let me know and I can explain any of the elements in further detail.

Thank you.

As you know, I am doing a project to learn how culture affects health decision-making. There are no right or wrong answers to any of the questions – only your opinion matters. I will not ask you about your previous relationships or behaviors – that is your choice to reveal that information to me. I want to keep what you say today confidential, so please do not share our conversation with anyone else. All you say today will be recorded, and I am taking the proper measures to ensure your identity is never revealed. I'll be asking you questions about your childhood, understandings of health and concert experience. A few of the questions may be difficult for you to answer depending on how much time has passed, so I'll accept the information that you remember. Please feel free to refrain from answering any of the questions if you are uncomfortable – just let me know that you'd rather not answer the question, and we'll move to another question.

I'm going to start the recorder now.

Do you have any questions for me before we begin?

1. Let's start by introducing ourselves. I'll go first. I was born and raised in Houston, I'm a full time graduate student and before that I was working in the nonprofit sector. Now, please tell me a little about yourself.
2. Please tell me about the household or households where you grew up.
 - Probe:* How did your household define the word health growing up?
 - Probe:* What actions did your household take when someone was not feeling well?
3. How do you define health now? (*Situational Theory of Publics – Problem Recognition*)
 - Probe:* What health issue do you consider to be most threatening to you?
 - Probe:* Why do you feel threatened by this particular issue?
 - Probe:* How have you learned information about this issue?
 - Probe:* [IF she says HIV, then ask] How long has HIV been the most threatening issue for you?
4. In what situations do you look for information about a health concern? (*Information Seeking*)

Probe: What media do you use to obtain that information?

5. In what situations do you engage in conversations about your health?
(*Information Sharing*)
Probe: Do the people you talk to share the same health opinions?
6. What happened the last time you had a health conversation?
7. To what extent do you feel like you have the necessary information and resources to maintain a healthy lifestyle? (*Agency/self-efficacy and Situational Theory of Publics -Constraint Recognition*)
Probe: Why do you feel that way?

Now I'd like to talk a little about what you think about HIV/AIDS. Please keep in mind that there are no right or wrong answers to any of these questions – your most honest and personal perceptions are the most important.

8. What is the first thing you remember learning about HIV/AIDS? (*Situational Theory of Publics – Problem Recognition*)
Probe: Where did you learn that?
Probe: As we talk about HIV, what comes to mind?
9. In what situations have you engaged in conversations about HIV specifically?
(*Information Sharing*)
Probe: With whom?
Probe: How did they make you feel?
Probe: What prompted you to discuss HIV with this person?
10. What types of things do you see in the media about HIV? (*Situational Theory of Publics – Problem Recognition*)
Probe: Do you feel like the messages talk to you personally?
Probe: Why/not?
Probe: How do the messages make you feel?
Probe: Have you ever acted on any of the messages?
Probe: [If yes] In what way? [If no] How come?
11. To what extent do you feel equipped with the information and resources to remain HIV negative? (*Agency/self-efficacy and Situational Theory of Publics - Constraint Recognition*)
Probe: Why do you think you feel that way?

Now I'd like you to think back to when you attended the Hip Hop for HIV Awareness concert.

12. Please tell me about your memory of the concert.

13. Why do you think 97.9 created the Hip Hop for HIV concert?
14. How did you first learn about the concert?
 - Probe:* How old were you?
 - Probe:* What was your initial reaction?
 - Probe:* Did you immediately recognize that the concert was targeted to you?
 - Probe:* [If yes] How so? [If no] How come?
15. What was your biggest motivation for attending the concert?
16. Please describe your testing process experience.
 - Probe:* Did you go alone? If not, who accompanied you?
 - Probe:* What emotions did you feel?
 - Probe:* What information did you learn?
17. How was the concert?
 - Probe:* Did you go alone? If not, who accompanied you?
 - Probe:* What HIV-related information did 97.9 provide during the concert?
 - Probe:* What other HIV-related information did 97.9 provide after the concert?
 - Probe:* Did you use any of the information after the concert?
18. If you could change one thing about your experience, including the marketing, the testing process, the concert or post-event communication, what would it be?
19. What is unique about how women see HIV?
20. What is unique about how Black people see HIV?
21. What is unique about how Black women see HIV that may be different from Black men or women who are not Black? (*Intersectionality/temporal context*)
 - a. *Probe:* Is there anything that must be uniquely addressed in communication sent to Black women about HIV?
22. How would you describe your opinion of 97.9 before the concert?
 - Probe:* Did your opinion change after the concert?
23. Is there anything else about your experience that you feel is important for me to know?

Thank you for your time and for sharing your experience with me.

Appendix D: Interview Guide for Individual Interviews (Radio Listeners)

Each major question is followed by the theoretical construct that the question is exploring in parenthesis.

Thank you for talking with me today. Before we begin, could you please read and review this consent form concerning your participation today. If you have any questions, just let me know and I can explain any of the elements in further detail.

Thank you.

As you know, I am doing a project to learn how culture affects health decision-making. There are no right or wrong answers to any of the questions – only your opinion matters. I will not ask you about your previous relationships or behaviors – that is your choice to reveal that information to me. I want to keep what you say today confidential, so please do not share our conversation with anyone else. All you say today will be recorded, and I am taking the proper measures to ensure your identity is never revealed. I'll be asking you questions about your childhood, understandings of health and concert experience. A few of the questions may be difficult for you to answer depending on how much time has passed, so I'll accept the information that you remember. Please feel free to refrain from answering any of the questions if you are uncomfortable – just let me know that you'd rather not answer the question, and we'll move to another question.

I'm going to start the recorder now.

Do you have any questions for me before we begin?

1. Let's start by introducing ourselves. I'll go first. I was born and raised in Houston, I'm a full time graduate student and before that I was working in the nonprofit sector. Now, please tell me a little about yourself.
2. Please tell me about the household or households where you grew up.
 - Probe:* How did your household define the word health growing up?
 - Probe:* What actions did your household take when someone was not feeling well?
3. How do you define health now? (*Situational Theory of Publics – Problem Recognition*)
 - Probe:* What health issue do you consider to be most threatening to you?
 - Probe:* Why do you feel threatened by this particular issue?
 - Probe:* How have you learned information about this issue?
 - Probe:* [IF she says HIV, then ask] How long has HIV been the most threatening issue for you?
4. In what situations do you look for information about a health concern? (*Information Seeking*)

Probe: What media do you use to obtain that information?

5. In what situations do you engage in conversations about your health?
(*Information Sharing*)
Probe: Do the people you talk to share the same health opinions?
6. What happened the last time you had a health conversation?
7. To what extent do you feel like you have the necessary information and resources to maintain a healthy lifestyle? (*Agency/self-efficacy and Situational Theory of Publics -Constraint Recognition*)
Probe: Why do you feel that way?

Now I'd like to talk a little about what you think about HIV/AIDS. Please keep in mind that there are no right or wrong answers to any of these questions – your most honest and personal perceptions are the most important.

8. What is the first thing you remember learning about HIV/AIDS? (*Situational Theory of Publics – Problem Recognition*)
Probe: Where did you learn that?
Probe: As we talk about HIV, what comes to mind?
9. In what situations have you engaged in conversations about HIV specifically?
(*Information Sharing*)
Probe: With whom?
Probe: How did they make you feel?
Probe: What prompted you to discuss HIV with this person?
10. What types of things do you see in the media about HIV? (*Situational Theory of Publics – Problem Recognition*)
Probe: Do you feel like the messages talk to you personally?
Probe: Why/not?
Probe: How do the messages make you feel?
Probe: Have you ever acted on any of the messages?
Probe: [If yes] In what way? [If no] How come?
11. To what extent do you feel equipped with the information and resources to remain HIV negative? (*Agency/self-efficacy and Situational Theory of Publics - Constraint Recognition*)
Probe: Why do you think you feel that way?

Now I'd like you to think back to when you attended the Hip Hop for HIV Awareness concert.

12. Why do you think 97.9 created the Hip Hop for HIV concert?

13. How did you first learn about the concert?
Probe: How old were you?
Probe: What was your initial reaction?
Probe: Did you immediately recognize that the concert was targeted to you?
Probe: [If yes] How so? [If no] How come?
14. Did you have friends who attended the concert?
15. What was your biggest hesitation for attending the concert?
16. What is unique about how women see HIV?
17. What is unique about how Black people see HIV?
18. What is unique about how Black women see HIV that may be different from Black men or women who are not Black? (*Intersectionality/temporal context*)
 - a. *Probe:* Is there anything that must be uniquely addressed in communication sent to Black women about HIV?
19. How would you describe your opinion of 97.9 before the concert?
Probe: Did your opinion change because of the concert?
20. Is there anything else about your experience that you feel is important for me to know?

Thank you for your time and for sharing your experience with me.

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