Abstract

Title of thesis: WOMEN'S MEANING MAKING OF CERVICAL CANCER
                        CAMPAIGNS: USING A CULTURAL APPROACH TO
                        REDEFINE WOMEN'S INVOLVEMENT WITH THEIR
                        HEALTH

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        The purpose of this study was to understand how women from different racial and

ethnic backgrounds make meaning of cervical cancer communication. In this exploratory

cultural study, the situational theory of publics provided the theoretical framework to

investigate to what extent women consider cervical cancer a problem, how they feel

connected to it, and what factors constrain them from seeking information. The study

used qualitative focus groups and one-on-one, in-depth interviews with African

American, Hispanic, and White women. Findings suggest that women feel differentially

involved to cervical cancer, and the distinctions are primarily based on age. Furthermore,

women tend to group reproductive health issues together rather than separating them.

This study expanded the situational theory of publics as well as a public relations theory

for women's health. Practical implications include cues to action and suggested factors

communicators can employ to improve culturally competent communication campaigns

and messages.

WOMEN'S MEANING MAKING OF CERVICAL CANCER CAMPAIGNS: USING A

CULTURAL APPROACH TO REDEFINE WOMEN'S INVOLVEMENT WITH

THEIR HEALTH

by

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DEDICATION

To Sue, for surviving

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Chapter 1 – Introduction

According to the National Cervical Cancer Coalition (NCCC, 2005),

approximately 10,520 new cases of cervical cancer will emerge in the United States, and

more than 3,900 women will die from cervical cancer this year. Approximately $2 billion

per year is spent in the United States on treatment for cervical cancer (National Cancer

Institute, 2004). Furthermore, Hispanic women experience a higher incidence rate of

cervical cancer than do non-Hispanic White women, and African American women have

a mortality rate from cervical cancer that more than doubles that of White women (NCI,

2004). Caused primarily by the sexually transmitted disease (STD) the human

papillomavirus (HPV), cervical cancer is the third most common cancer of the female

genital tract (NCCC, 2005).

Cervical cancer is one of the most preventable types of cancer. By reducing risk

factors such as smoking, practicing unsafe sex, and using birth control pills for prolonged

periods of time, women can reduce their chances of developing cervical cancer. More

importantly, having regular Pap smears can detect HPV infection and pre-cancers.

Treatment of HPV can stop cervical cancer before it develops into an invasive cancer

(American Cancer Society, 2005). Since the patterns of development of cervical cancer

provide multiple opportunities for detection and treatment, "death from this disease

should be exceedingly rare, occurring only in women who are not screened and treated

appropriately" (Dignan, Michielutte, Wells, & Bahnson, 1994).

However, disparities exist in access to Pap smears, and they exist in rates with

which women have Pap smears performed. The American Cancer Society (2005) noted

that between 60 and 80 percent of U.S. women have not had a Pap smear performed in

the past five years, and some women – particularly older women, African American women, and women with low incomes – have never received a Pap test. Furthermore, Dignan et al. (1994) explained that obtaining a Pap smear is only one of the two necessary procedures for cervical cancer prevention: the other is the follow-up Pap smear to examine possible abnormal cell developments more closely. Thus, there are several steps to prevention.

As cervical cancer is highly preventable, it is therefore the job of communication to raise awareness about cervical cancer detection and encourage women to routinely have tests performed. Communication campaigns can help lower the incidence of cervical cancer and work towards closing the racial and ethnic disparities in the rates of incidence. The first step in the communication process is to understand how women make meaning of cervical cancer and the media and dialogue surrounding it. The situational theory of publics, a public relations theory, helps communicators do this by identifying the extent to which a public has seen information about a topic, what the information means to the public, and how much information seeking a public actively conducts about a topic. This study applied the situational theory to an exploration of how women make meaning of cervical cancer campaigns in order to assess the theory's utility in the arena of women's health communication and in order to better understand how campaigns can be better designed for women's everyday lives.

Implications of Study

The purpose of this study was to understand how women from different racial and ethnic backgrounds made meaning of cervical cancer communication. Using feminist standpoint theory as my guiding epistemology, I conducted a qualitative, cultural study to

learn about how African American, Hispanic, and White women make meaning of cancer communication[1]; if/how women seek information about cancer; and if they do, why/not they comply with the messages. In this exploratory cultural study, I used the situational theory of publics (Grunig & Hunt, 1984) to investigate (a) what type of publics groups of women constituted, (b) how likely they were to seek information about cervical cancer, and (c) based on these findings, to what types of cervical cancer messages they were likely to respond.

The findings contribute to the field of public relations by extending the situational theory of publics into health communication contexts and by better understanding publics according to gender, race, ethnicity, and other cultural delineations. The findings also contribute to a theory of women's health communication (Aldoory, 2001) by adding a layer to the developing theory about how racial and ethnic differences can influence experiences and perspectives. The proposition here is that race, ethnicity, and culture are important meaning making antecedents as well as products. Thus, communicators should not only consider and be sensitive to these factors in developing women's health communication programs and messages, but communicators should intently, humbly, creatively, and dialogically try to understand how women use these cultural indicators to

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[1] I had significant trouble determining the terms I would use for each group of women. I am very sensitive to referring to a person's race, ethnicity, culture, heritage, or identity incorrectly. Therefore, this aspect of my study leaves me somewhat insecure. I had trouble choosing between 'Hispanic' and 'Latina,' as these are the two references used most in the literature cited in this study. I also had trouble deciding between 'White/White' versus 'Caucasian' and 'African American' versus 'black/Black' versus 'Black American'. I did not find one consistent usage of any of these terms, nor did I find another researcher that pointed out why which term is more appropriate than another. To negotiate this situation, when citing participants or previous researchers, I tried to use the term they used during the interview or study, respectively. Therefore, in the literature review, results, and discussion sections, the terms may vary. This technique is reflected in feminist standpoint epistemology theory. However, I chose the term Hispanic in the other sections of this study where I am using my own voice because as a woman with some Colombian heritage, I was raised with a family that used the term Hispanic to refer to that side of our family. I choose 'African American' because this is the term I see most often in literature about cancer and women. Finally, I will use 'White' for White/Caucasians, because I refer to myself as White.

situate cervical cancer communication in their personal worlds. For women's health, this grassroots pursuit of meaning making can improve cervical cancer communication to women by contextualizing the messages in personal, cultural venues and symbols. Finally, this thesis will suggest ways to create more culturally appropriate communication campaigns and messages targeting the African American, Hispanic, and White women populations.

The thesis first presents a literature review regarding (a) a conceptualization of cultural studies and past cultural studies of women, health, and media; (b) the situational theory of publics and past studies of women, health, and racial/ethnic differences; and (c) effects of cervical cancer communication campaigns on women. The methodology used is then discussed along with the sample and the data analysis procedures. Finally, results, theoretical and practical implications, and limitations of the findings conclude this paper.

Chapter 2 – Literature Review

Literature from several disciplines informed my study and helped me develop my research questions. First, I will review literature that defines the cultural studies approach in order to conceptualize meaning making as well as situate the importance of understanding the cultural codes important to a public. Included in this section are cultural studies that have examined women's meaning making of a phenomenon, how mediated texts represent about the phenomenon, and demonstrate methodological procedures that make cultural studies distinct. Secondly, I will review public relations literature describing the purpose of and variables comprising the situational theory of publics as well as studies that explore the way the theory applies to women publics, publics from different racial and ethnic backgrounds, and publics concerned about health threats. Lastly, I will review cervical cancer communication literature in order to understand the results of community interventions and their implications regarding race, ethnicity, and factors relating to the motivations and constraints to performing cervical cancer behaviors.

Cultural Studies Approach/Perspective

Culture can broadly be understood as the collection of all manners of approaching life as well as the ongoing processes of human integration of meaning into the surrounding world (du Gay et al., 1997). In another sense, culture can be a group that shares "conceptual maps, shared language systems and the codes which govern the relationship of translation between them" (Hall, 1997, p. 21). Culture also takes into account the oppositions that exist in life naturally. Frow and Morris (2003) argued that culture incorporates these oppositions and tensions, and they define culture as the

continual process that social groups undergo in explaining their identifications and existence in relation to the outside world. The authors define cultural studies according to the never-ending tension social groups experience in self-identification in relation to external – possibly contradictory – forces. However, to clarify, although cultural studies can be many things, cultural studies researchers firmly believe that "cultural studies cannot be just anything" (Nelson, Treichler, & Grossberg, 1992, p. 3).

Humans use culture tangibly by means of *representation*, which is a process of symbolization (Hall, 1997). Humans use representation to link intangible concepts that have been assigned meaning to likenesses in the form of language, signs, and images, which are the enabling communication tools between humans. Hall delineated two systems of representation: one in which although individuals' conceptual maps can be totally different from each other, they can overlap and share concepts, thereby creating a culture; and the second within which we use a similar language as the fundamental, essential means to communicate about the common culture. According to Hall, humans use signs/codes to represent objects, places, and events from our conceptual maps, which enable translatability between concepts and language. Finally, representation requires a level of cultural relativism amongst differing cultures because inherently, qualities of representations will not be equal, and translation of these values is essential to the co-existence and harmonization between adjacent cultures.

We represent "things" primarily through language, which is a collection of signs that we give meaning *to* and that we exchange to make further meaning (du Gay et al., 1997). Meanings are not inherent inside physical and intangible phenomena; instead, they are socially constructed by humans around and inside an object, event, or place; therefore

groups of people who produce or "make things mean" in similar ways can be considered

a culture (du Gay et al., 1997; Hall, 1997). We use meanings and language to express

complex ideas to others; therefore, we cannot look only at things to ask for their

meanings – we must ask those who use them in their cultures what the objects mean to

them (du Gay et al., 1997; Hall, 1997). By examining media and texts and people's words

and comparing current texts to previous texts, we can see how images and things do not

carry meaning but instead how they interact with each other (Hall, 1997; Lindlof &

Taylor, 2002).

A popular procedural theory used to examine meaning making from multiple

perspectives is the *circuit of culture* (Acosta-Alzuru, 2003; du Gay et al., 1997). du Gay

et al. (1997) outlined the steps in the circuit as representation, identification, production,

consumption, and regulation. Codes are essential to understanding the circuit. As

mentioned before, we use codes because they have the ability to translate meanings and

language back and forth (Hall, 1997). Interpreting codes in order to produce meaning

comes from the processes of encoding and decoding. The meaning-maker puts meaning

into a code and then the receiver internalizes meaning from the code (Hall, 1993; Hall,

1997).

Hall (1993) explained that the processes of encoding and decoding are essential

within the circuit of culture and communication. They enable production (by the makers

of the object and message) and consumption (the absorption of the message by the

audience) within the circuit. The cultural object about which communication occurs

carries constructed and implanted meanings and messages that producers embed within

the object, using codes and language. This is the process of encoding. The audience then

translates the discourse, using their own social practices and cues to decode the message from the representative object (Hall, 1993). Hall noted that although these steps are autonomous, the encoding/decoding steps are "determinate moments" required in complete communication consumption (p. 91).

Another level of cultural representation is the concept and incorporation of *the 'other'* into the cultural studies approach. Otherness is a popular topic in representation because researchers strive to understand better how to accurately represent people and places significantly different from a dominant culture (Hall, 1997), or, more pointedly, those within the socio-economic political system that are disempowered. In the context of the media, Hall referred to how gender and sexuality differences are typically linked with racial and ethnic differences: "in representation, one sort of difference seems to attract others, thereby adding up to the 'spectacle' of otherness" (Hall, 1997, pp. 231-232). Therefore, cultural studies examine how culture becomes the "site of profound struggle between the members of dominant and marginalized groups" (Lindlof & Taylor, 2002, p. 58), and these marginalizations typically aggregate around issues of gender, class, and race. And each culture forms an "economy" in which "texts comprise the medium for evolving relationships among producers, performers, and consumers" – or audiences – of texts (Lindlof & Taylor, 2002, p. 58). The powerful political economy, the preferences of the members within the culture, and the intertextuality – or interactivity – of the texts contribute to the possibility of textual meaning within a culture.

Thus, these differences are necessary for meaning to exist or else we would not have nuances through which to compare and therefore identify meaning and culture (Hall, 1997). This is why discussion with the 'other' is necessary so we can see the

spectrum of meaning making, order things, and communicate with the nuances of all cultures. In this study, I will explore the premise Hall (1997) made that interaction/dialogue with the 'other' is necessary, even if ambivalence in an object is discovered, for I will talk with three groups of women from different racial and ethnic backgrounds to discover the nuances of meaning necessary when communicating with each of them. I will also investigate possible effects of Lindlof and Taylor's (2002) proposition that when a producer of one culture creates a text for another culture, ambiguity, confusion, and controversy can arise because the encoding and the decoding processes may not follow the same ideologies.

Cultural studies of women. Several studies have examined women and different types of media in order to position women in the contexts that set them apart from men (Acosta-Alzuru, 2003; Aldoory, 2001; Bobo, 1995; Duncan & Robinson, 2004; Grodin, 1991; Martin, 2001; Press & Cole, 1999; Radway, 1984). In her study of women's meaning making of romance novels, Radway (1984) decided that instead of studying the actual texts of the novels, it is most important to see what leads women to actively place "sense to lexical signs in a silent process carried on in the content of her ordinary life" (p. 8), by studying what the characters, story lines, and romance elements mean to the readers. Her interviews and small group discussions indicated that women used these novels as ways to reject the patriarchal institution of marriage in which they tend to others' needs before their own, and these novels represented a sort of " 'declaration of independence' " (p. 213). Similarly, Grodin (1991) conducted prolonged one-on-one interviews with a diverse group of women to investigate their meaning making of self-help books in their lives. In her reception and audience analyses – two methods used

within the cultural studies methodology that examine how common experiences within a culture reconcile perceptions of messages within the media – she found that the women transformed the texts in order to make the texts meaningful in their struggles to find commonality (about their perceived problems) among other women.

In a study about women's perceptions of media, Acosta-Alzuru (2003) looked at how Venezuelan gender roles heavily influence texts, which she saw in the ambiguities of images and meanings in the production, consumption, and representation of feminism in a popular Venezuelan soap opera. Using the circuit of culture (du Gay et al., 1997) as her framework, she found that although the producers, actors, and audience members respect the rights of women as equal to men, the terms *feminism* or *feminist* are generally rejected in Venezuelan society, even though the show provides many depictions of feminism: "Writers, actors, media executives, texts and audiences are caught in a ritual process of establishing shared meanings, which is embedded in culture and power differentials" (p. 288).

Press and Cole (1999) also studied women's perceptions of health issues within the media. In their focus groups about how women construct meaning from entertainment media coverage of abortion issues, Press and Cole (1999) used grounded theory (Glaser & Strauss, 1967) to guide their study because they wanted themes to emerge rather than confirm or disconfirm a previously constructed hypothesis. The grounded theory and cultural studies approaches helped them identify social class as well as societal power differentials as major determinants in these women's opinions – and divisions among each other – about abortion.

With regards to women, health, and media, Aldoory (2001) used grounded theory (Glaser & Strauss, 1967) to explore meaning making of health messages among five focus groups and 10 one-on-one interviews with women of different subcultures that varied according to race, class, sexual orientation, age, educational level, and professional position. She found that women use constructs like a consciousness of everyday life and personal health, media usage and preference, and self-identity as antecedents to how they make meaning of health messages. An important finding from Aldoory's study reflects the contradiction that although health communicators strive for and tout cultural competency, many women in the study did not see themselves reflected in many media messages, which is an illumination of Frow and Morris' (2003) argument that cultural studies examine the tensions and controversies among conflicting cultures.

Although not focusing on media, Martin (2001) conducted a cultural study comparing two different cultures of women. She examined the similarities and differences in medical culture's and ordinary women's perceptions of the female reproductive system. She conducted extensive interviews with women to learn about the cultural assumptions they make about hormones, their menstrual periods, and also "the nature of women, of men, [and] of the purpose of existence" (p. 13). She assumed that (a) medical culture experiences women's bodies differently than do the women themselves, (b) these underlying assumptions about women's bodies are taken for granted in society, and (c) understanding these differences is essential to understanding the everyday woman's everyday experiences. By studying women and medical texts, Martin found that these "consequences of the medical lexicon about women's bodies" (p. 14) permeate in

not only women's perceptions of how medicine views their bodies but also in how they view themselves.

In terms of cultural studies conducted about African American women's meaning making, two studies explored women's perceptions of different types of texts. By using the grounded theory approach (Glaser & Strauss, 1967) to guide a focus group of African American women examining health/fitness magazine messages, Duncan and Robinson (2004) found that the women perceived gender and class to boldly interact with race in significant ways that shape these women's experiences and culture. Bobo (1995) used novels and films about African American women as her probing ground. Cultural studies approach guided her exploration into the pervasiveness of Black female culture in African American women's experiences with media around African American history, society, and relationships. She used a triangulated approach by analyzing texts herself as well as interviewing African American women about their perceptions of these texts. Her findings contributed to Collins' (1990) theory of Black female standpoint because the women she interviewed proved to be empowered, adroit, critical readers of the surrounding societal factors influencing their lives.

Cultural studies' procedures. Cultural studies have some distinct methods. Acosta-Alzuru (2003) used the circuit of culture (representation, identification, production, consumption, regulation) as her research tool to examine the representation of feminism in Venezuelan telenovelas (soap operas). In order to understand how the text *represented* feminism in the show and how the audience members formed a negotiated identity of the feminist, she conducted a textual analysis (*identity*) and one -on-one interviews and small group interviews with producers (*production* and *regulation*), actors

(*production*), and audience members (*consumption*) of a particular, popular telenovela in Venezuela. Bobo (1995) also conducted a triangulated cultural analysis, similar to Acosta-Alzuru's (2004). She examined the texts of the novel and the film rendition of *The Color Purple*; conducted one-on-one, in-depth interviews with African American women who had seen the movie about their meaning making experiences of the images and concepts within the movie; performed a textual analysis of another film, the independently-produced *Daughters of the Dust*; and finally, conducted another set of one-on-one, in-depth interviews with African American women who had seen *Daughters of the Dust*.

Some cultural studies, however, have taken a single method approach but nonetheless examined experiences and meaning making. Similar to Bobo (1995) and Acosta-Alzuru (2003) in their use of media text as the conversation topic in interviews/group discussion, Duncan and Robinson (2004) provided African American magazines containing a regular health/fitness column or article to a focus group of recently college graduated, African American women. The women were asked to discuss the meanings they perceived in the body images portrayed (of African American young women) in the magazines.

Finally, Radway (1984) conducted more than 60 hours worth of one-on-one interviews with middle-class women regarding their feelings of what romance novels represent to them. Radway's (1984) sampling method was notable in that she worked with her informant extensively, a bookstore employee that had developed a customer base of 50 to 75 women who regularly consulted her for romance novel suggestions as well as who received a newsletter the employee developed and distributed about the

novels. Radway recruited women based on the informant's recommendations of whom to contact. With these women, she conducted one-on-one interviews, led small group discussions, and administered extensive questionnaires asking about participants' demographics as well as attitudes toward the novels (in order to look for themes in the women's meaning making).

Bobo (1995) emphasized the importance of cultural studies' inclusion of unexpected responses, as they are typically reflections of backgrounds and experiences that are necessary to understanding women's media responses, particularly those of groups that are not usually included in analyses, like African American women. Bobo made sure to delve deeper into the participants' responses to understand "the totality of their lives and within the full range of black women's past" (p. 100). In another effort to discover the "totality" of women's meaning making about a topic, Martin (2001) conducted a cultural analysis to explore if women from different social and economic conditions approach health issues differently. She also compared how medical culture perceives the women's body, reproductive system, and life to how ordinary women perceive the same thing. To do this, she recruited more than 160 women for individual, in-depth interviews, with the number of women evenly distributed among three periods during a women's total life: after puberty and before childbearing age; during childbearing and childrearing ages; and during and after menopause. She also attempted to recruit half of the women from either middle-class or above, and the other half from low-income or below (she found that class interacts significantly with health issues). In addition to her many interviews, she also immersed herself in medical culture by attending numerous medical lectures, reading medical school texts and handbooks, and

having conversations with medical colleagues and graduate students at the Johns Hopkins University's medical school in Baltimore, Maryland. She did note, however, that her study is limited because she did not interview doctors and other medical personnel near to the extent that she interviewed ordinary women.

Press and Cole (1999) conducted qualitative methods most similar to how I conducted mine. The authors interviewed groups of women in the women's homes. The women were asked to invite friends and family members who held similar attitudes toward abortion to join the group (researchers conducted 34 groups in a 5-year span, which included 108 women). Researchers recorded the data of the women's words but also analyzing the women's "everyday talk" so to understand how they make meaning *with each other* (Lunt & Livingstone, 1996). Furthermore, Press and Cole used the setting of talking in a friend's home as an effort to replicate casual conversations women have while watching television. Finally, they used women who knew each other in order to promote more intimate, nonconfrontational discussion than may occur if the participants were strangers (although the authors propose that disagreement and discord within focus groups is an acceptable form of data). In the semi-structured focus groups, they spoke with the women in casual conversation, showed a prime-time television entertainment show dealing with abortion, and led a group discussion about the women's perceptions of the show afterwards.

Situational Theory of Publics

Many studies have used the situational theory of publics (Grunig & Hunt, 1984) to understand what type of publics congregate around an issue and how these publics should be approached with communication messages and relationships (please see J. E.

Grunig, 1997, for a comprehensive list of research studies on the situational theory of publics). The theory is useful for communicators because it provides a framework within which an organization can research its publics, conceptualize the level of involvement the publics hold regarding the organization, prioritize the publics in terms of immediacy of activity, and create appropriate communication strategies to create and maintain relationships with the publics.

Publics. According to Dewey (1927) as cited by Grunig and Hunt (1984), a public is a group that detects and recognizes consequences (i.e., problems) from an organization's actions. The public then organizes to do something about the problem. There are four types of publics that are positioned along a spectrum of activity as a public: nonpublic (low end of range of information seeking activity), latent public, aware public, and active public (high end of range of information seeking activity) (Grunig & Hunt, 1984).

Three dependent variables and two independent variables affect with which type of public an organization is communicating. There are three predictors of information seeking activity: (1) *problem recognition* is the extent to which a public perceives an issue or action as a problem; (2) *constraint recognition* is the extent to which a public perceives constraints – or barriers – to achieving or acting according to the suggested behavior (by the organization); and (3) *level of involvement* is the amount of "connectedness" a public feels toward an issue, action, or organization (Grunig & Hunt, 1984). Problem recognition indicates to what extent a public will engage in *information seeking* (active communication behavior) or *information processing* (passive communication behavior). Measuring a public's demonstration of these variables

indicates which publics are likely to become active publics, and the situational theory also helps with predicting when and how active publics are likely to gather around an issue to do something about it (Grunig, 1997).

Health context. Some studies testing the situational theory of publics have used the context of health communication to determine activity of a public (Aldoory, 2001; Cameron & Yang, 1991; Grunig & Childers, 1988; McGrath, 1999; Pavlik, 1988). Aldoory (2001) studied antecedents to involvement among various subgroups of women by examining their feelings regarding various health issues. Cameron and Yang (1991) tested the level of personal distance participants perceived in regards to AIDS messages, and found that adding variable levels of personable closeness measurements to the situational theory could help practitioners better predict the activities of publics. Pavlik (1988) observed in heart disease campaigns that public relations practitioners should intimately research the complexity of knowledge within a public to determine the target levels of involvement to aim campaign messages.

Women as public. Very few studies have used the situational theory to understand women as a public and their specific information seeking behaviors. Aldoory's (2001) study initiated the development of a public relations theory specific to women and their health issues. Slater, Chipman, Auld, Keefe, and Kendall (1992) conducted a study testing the situational theory of publics and using only women as the sample. The authors explored women as primary buyers of produce to evaluate the effectiveness of campaign messages regarding pesticides. The authors advocated adding cognitive response approaches to the information seeking variable in order to develop more pointed messages; however, the motivation behind the sampling of women was limited to their

purchasing patterns and thus does not advance any public relations concept specific to women as publics or women's health as a public relations issue.

As Aldoory (2001) pointed out, the situational theory is important in health communication because it can help campaign planners understand where a public sits on the spectrum of connection to a specific health threat in a sea of health messages, and when a public is likely to change behaviors in order to preserve health. Understanding the motivations and constraints a public feels toward a health issue can help campaign designers craft messages to help move individuals from latency to awareness so they will be more apt to adopt suggested health behaviors. She notes, however, that very few situational theory studies have used women as the sample in order to examine and embrace women's unique and specific health issues, which could provide a useful testing ground for the theory. Mendias, Clark, and Guevera (2001) asserted as well that gender affects health significantly because of power differentials (Stern, 1996), and factors have been found to lead to a higher utilization of health care facilities among women than men. Therefore, it is logical that women and health should increasingly become the focus of situational theory studies. Since women have unique power positions, and health is a common media topic that drives communication campaigns, women and health could elaborate the situational theory as well as provide extensive practical applications to health organizations that communicate with women.

Racial/ethnic differences. Only a handful of studies were found that purposefully sampled participants from non-White/Caucasian races and ethnicities (Aldoory, 2001; ReVelle, 1995; Sha, 1995). Sha, for example, tested the situational theory of publics to determine if the variables changed within different cultural contexts. She found that

differences in racioethnicity were linked to all the variables within the situational theory except in predicting constraint recognition.

Emphasizing the necessity of incorporating race, ethnicity, and culture into multiple aspects of public relations theory and research, Pompper (2005) evaluated the extent to which the population of articles from public relations journals revealed characteristics of Critical Race Theory (CRT). She found that 15.8% of the total articles demonstrated some form of CRT in either its study topic or focus; epistemology or methods; samples only; authors' worldview or philosophy; or effectiveness antecedent or remedy. To this, she argued "it is time for CRT in public relations" (p. 155), a call for which she provided several practical suggestions for scholars. The suggestions included "embrac[ing] a think race, ethnicity, and culture mantra" (p. 157); connecting more with research participants by providing the context for which their cultures are situated; triangulating methods more and involving participants more in data analysis; and working more with international public relations students. By adopting more CRT-driven studies, public relations scholarship makes fewer assumptions about the realities of public relations from the perspectives outside the White, hegemonic worldview.

Although a few situational theory studies have examined how race, ethnicity, and gender influence the type of public formed, no study found examined all three, using a specific health issue as the context. The situational theory of publics provides a useful framework through which to conceptualize women's activity as publics toward women's cervical cancer communication. The variables in the situational theory guide my understanding of women's meaning making. I use the variables in the situational theory

to identify specific cultural symbols and concepts women use to seek information or perform behaviors regarding cervical cancer.

Cervical Cancer Interventions

  Methodological patterns in research. Although the majority of cancer interventions aimed at women promote breast cancer prevention and screening, a sizable amount of studies have reviewed the extent of awareness, knowledge, screening, and follow-up behaviors of women. However, the literature reflects several demographic and methodological trends. First, the cervical cancer screening interventions and awareness surveys are focused exclusively toward women of color and mostly toward women of low income and of ages 40 and older, and the studies largely eliminate White women and women from racial and ethnic backgrounds other than African American and Hispanic women. As women from minority groups and women with low incomes tend to be at higher risk for cervical cancer because of lack of education about detection methods combined with lack of insurance or money to pay for the tests (Suarez, Nichols, Pulley, Brady, & McAlister, 1993), the majority of studies focused primarily on Latinas and specifically, Mexican-American women (Ell, Vourlekis, Muderspach, Nissly, Padgett, Pineda et al., 2002; Fernandez-Esquer, Espinoza, Torres, Ramirez, & McAlister, 2003; Goel, Wee, McCarthy, Davis, Ngo-Metzger, & Phillips, 2003; Harmon, Castro, & Coe, 1996; Hunt, de Voogd, Soucy, & Longworth, 2002; Ramirez & McAlister, 1988; Ramirez, Suarez, McAlister, Villarreal, Trapido, Talavera, et al., 2000; Ramirez, Villarreal, McAlister, Gallion, Suarez, & Gomez, 1999; Suarez, Lloyd, Weiss, Rainbolt, & Pulley, 1994; Suarez et al., 1993; Wu, Black, & Markides, 2001; Yancey, Tanjasiri, Klein, & Tunder, 1995) as well as African American women (Dignan, Bahnson, Sharp,

Beal, Smith, & Michielutte, 1991; Dignan, Michielutte, Jones-Lightly, & Bahnson, 1994;

Dignan, Michielutte, Wells et al., 1994; Michielutte, Dignan, Bahnson, & Wells, 1994;

Paskett, Tatum, D'Agostino, Jr., Rushing, Velez, Michielutte et al., 1999; Suarez et al.,

1994; Yancey et al., 1995).

In addition to promoting cervical cancer knowledge, prevention, and detection,

cervical cancer studies to date mostly examined one or multiple aspects of cervical cancer

interventions: (1) surveying the extent of knowledge and awareness of cervical cancer

(Dignan et al., 1991; Dignan, Michielutte, Wells et al., 1994; Harmon et al., 1996); (2)

measuring the extent to which certain populations have ever had a Pap test or to

understand general screening behaviors (Fernandez-Esquer et al., 2003; Goel et al., 2003;

Harmon et al., 1996; Paskett et al., 1999; Suarez et al., 1994; Suarez et al., 1993; Wu et

al., 2001; Yancey et al., 1995); and (3) appraising follow-up screening behaviors after

receiving abnormal Pap smears (Ell et al., 2002; Hunt et al., 2002; Michielutte et al.,

1994). The majority of the studies used quantitative survey methodology to obtain data,

although some studies used qualitative interviews to explore constraints women face in

obtaining Pap tests and following-up on abnormal Pap tests (Dignan et al., 1991; Hunt et

al., 2002; Suarez et al., 1993), observational methodology to evaluate factors contributing

to successful follow-up behaviors (Ell et al., 2002), and quantitative content analysis to

assess the number of articles relating tobacco use to cervical cancer incidence in popular

African American media (Hoffman-Goetz, Gerlach, Marino, & Mills, 1997).

Landmark interventions programs. Overall, cervical cancer interventions have

seen an increase in cervical cancer prevention and detection behaviors in minority

populations. One major intervention, the Forsyth County Cervical Cancer Prevention

Project (FoCaS), aimed at African American women in Forsyth County, North Carolina, used a combination of quasi-experimental methods, surveys, monitoring of media coverage, and field qualitative interviews to improve screening rates and understand women's barriers to screening. Their intervention discovered that awareness of cervical cancer increased in all mass media except for newspapers (Dignan et al., 1991), that a combination of mass media awareness and direct education programs are an appropriate mix of techniques to increase awareness (Dignan, Michielutte, Wells et al., 1994), and that lack of awareness and lack of health care access are reasons women do not follow-up on abnormal Pap tests (Michielutte et al., 1994). Finally, the authors attributed the success of the increased screenings in the intervention city to the multi-theoretical framework used along with the combined tactical approach of mass media, interpersonal education, community involvement, and clinic-based needs assessment that were tailored to the unique needs of the city (Paskett et al., 1999).

Similarly, the *Su Salud, Su Vida* intervention program, targeted primarily to Mexican women and Mexican-American women in southern regions of Texas, found increased rates of screening for breast cancer and cervical cancer. One survey found that women younger than 40 years old had more information about cervical cancer because they were the ones to be more involved in family planning and other reproductive health issues, whereas older women were more likely to learn about cervical cancer from their doctors, although they did not necessarily visit their doctors as often (Fernandez-Esquer et al., 2003). These authors suggested that future cervical cancer interventions focus on women according to their age segments. Likewise, Suarez et al. (1993) conducted a baseline survey on the influence of social networks on women's screening rates, and the

authors recommended that communicators use social networks to send messages about prevention and screening. Finally, the researchers also examined barriers to screening and found that modeling and use of interpersonal networks provide effective, low-cost interventions because they address the primary constraint women face in obtaining Pap tests, cost (Suarez et al., 1993).

Relevant Findings. A number of studies have examined whether mass media would be effective in promoting cervical cancer among certain female populations. The interventions using mass mediated materials such as television public service announcements (PSAs), radio interviews (both in English and Spanish), posters, pamphlets, newsletters, public bus advertisements, newspapers, and culturally sensitive videos played in physicians' waiting rooms showed increased cervical cancer screening behavior among women targeted (Dignan et al., 1991; Dignan, Michielutte, Wells et al., 1994; Fernandez-Esquer et al., 2003; Paskett et al., 1999; Yancey et al., 1995). Materials portraying models similar to the targeted populations were found to be more effective in increasing women's self-efficacy and motivation to obtain Pap tests (Paskett et al., 1999; Suarez et al., 1994; Suarez et al., 1993).

Several studies also tested interpersonal communication tactics for their effectiveness in increasing Pap screenings. A few studies analyzed the interpersonal networks in which women participated. For example, in the local health intervention in regions of south Texas called *Su Salud, Su Vida* targeted primarily at Mexican-American women and some African American women for increasing cervical and breast cancers screening techniques, Suarez et al. (1993) found a linear relationship between the size of the social network and the rate of Pap and mammogram screening; thus, the authors

implied that the size of social networks, the frequency of contact, and the types of activities may increase screening among minority populations. In the same *Su Salud, Su Vida* study, Suarez et al. (1993) used social learning theory and the diffusion of innovations theory to build networks throughout the participating communities by recruiting volunteers to be trained to model to women how to get screened. Both participating communities increased in screenings. Other interventions focusing on interpersonal communication used interpersonal education programs in health clinics (Michielutte et al., 1994) and combined interpersonal approaches, such as the SAFe (Screening Adherence Follow-up) model which merges health education, individual counseling, and systems navigation (Ell et al., 2002).

Theoretical frameworks. The most widely used theory to shape interventions was social learning theory (Bandura, 1977), with social modeling (Dignan, Michielutte, Wells et al., 1994; Paskett et al., 1999; Suarez et al., 1993), social reinforcement (Suarez et al., 1994), and self-efficacy (Paskett et al., 1999). The health belief model (HBM; Rosenstock, 1974a; Rosenstock, 1974b; Rosenstock, Strecher, & Becker, 1988) and its elements of perceived barriers, benefits, susceptibility, severity, self-efficacy, and cues to action were used to understand that Latinas benefit from culturally appropriate and individual support for interventions (Ell et al., 2002). The FoCaS Project studies used social marketing (Andreason, 1995) to segment publics according to the different blends of mass media the publics use for health information (Dignan et al., 1991), which the authors suggested can be used effectively to educate healthcare providers as well about the benefits of educating patients about cervical cancer screening (Dignan, Michielutte, Wells et al., 1994).

Research Questions

Given the literature and theory on cultural studies, situational theory of publics, and cervical cancer communication, the following Research Questions were developed to guide the data collection and data analysis of this thesis study.

RQ1: How do women from different racial and ethnic backgrounds recognize the problem of cervical cancer, perceive constraints to comply with cervical cancer messages, and perceive their level of involvement?

RQ2: What factors contribute to the ways women of different racial and ethnic backgrounds make meaning of cervical cancer messages in media?

RQ3: What type of public(s) do women of different racial and ethnic backgrounds represent regarding their communication behavior toward cervical cancer campaigns?

Chapter 3 – Method

Overview of Method

Qualitative methods were used to gather and analyze data. I chose qualitative methodology – a cultural approach – as my underlying vision for my research, which incorporates in-depth interviews as well as focus groups. My way of knowing – my epistemology – represents the feminist standpoint theory, which observes research from the perspective of situated knowledge. These methods, methodologies, and epistemology will be discussed in more detail later in this section.

I triangulated my methods in order to achieve a higher degree of validity than if I had used a single method. I conducted two types of methods with the participants – interviews and focus groups – and in these sessions, I asked participants to share with me their perceptions of media materials I provided them from various cervical cancer campaign that target women. By exploring the women's perceptions of cervical cancer communication messages, I investigated the *consumption* process within the circuit of culture (du Gay et al., 1997). Using these two methods increased the validity of my study because the findings come from different sources in a "display of multiple, refractory realities simultaneously" (Denzin & Lincoln, 2003, p. 8).

Qualitative Approach

The qualitative approach to inquiry is complex but open. Potter (1996) argued that qualitative research is hard to define in a single conceptualization because of the approach's constantly changing structure and make-up as well as its multiple backgrounds, origins, and existing forms. On a more individual level, Lindlof and Taylor (2002) conceptualized qualitative research as approaches interested in "human

understanding" (p. 19), with attempts to study how humans internalize, analyze, interpret, incorporate, articulate, produce, and share phenomenon in society and relationships around them, using their talk and gestures as the units of measurement. To this point, Denzin and Lincoln (2003) explained that as a "human discipline" (p. 1), qualitative research has emerged in many humanistic studies, such as anthropology, sociology, education, social work, communication, business, and nursing.

Researchers and theorists agree that qualitative research is interpretive and naturalistic because it allows participants to show researchers what the world means to them (Denzin & Lincoln, 2003; Emerson, Fretz, & Shaw, 1995; Lindlof & Taylor, 2002; Potter, 1996). The naturalism and the openness of the approach seem to fit together, for Denzin and Lincoln (2003) liken the qualitative researcher to a *bricoleur* as someone able to draw upon multiple subjects to make conclusions as well as use various personal and environmental faculties as tools of learning humanity around her/him.

Other characteristics constitute the dynamic, humanistic nature of qualitative research. Qualitative researchers are eager to investigate the barriers in life and place findings in the context of the world the participants experience (Denzin & Lincoln, 2003). Qualitative inquiry is a place for seeing vitality and "cross-fertilizations, catalytic dialogues, and a prevailing sense of participation in a living revolution," (Gergen & Gergen, 2003, p. 576). In order to observe this, qualitative researchers typically conduct interviews and participant observation to inquire into members' meanings and attempt to obtain thick, rich descriptions that allow data – the words and actions – to tell the story (Denzin & Lincoln, 2003).

Feminist Standpoint Epistemology

I feel it is important for me to share my epistemology that drives my research as well as this project. My epistemology contributes to why I research women and what goal I hope to accomplish in this study, which is to advocate "for rather than merely about women" (Olesen, 2003, p. 333).

I identify as a feminist qualitative researcher representing the feminist standpoint epistemology, which is my "way of knowing." Standpoint theory is not only about women's experiences but also about women's situated being, frame of reference, and what we intrinsically know inside. Standpoint theories use the everyday experiences of marginality as a ground for theory building because the theories were born in the idea that academia highly neglected women's perspectives and participation in research, as researchers, as participants, and as sources for research topics (Harding, 1991; Minnich, 1990).

It is an appropriate epistemology to drive this research because it has similar roots to the cultural studies approach. The standpoint theories support the cultural studies methodology because cultural theorists recognize that knowledges – or ways of knowing – are not the same, but instead, are socially situated from each individual's world, and each knowledge represents a differential influence of power (Haraway, 1988; Harding, 1991; Hartsock, 1983). Similarly, feminist standpoint theorists believe knowledge stems from oppression of the personal, the social, and the biological, and that shared knowledge (and shared experiences) is necessary because it tells us more about the general experiences of women rather than idiosyncratic accounts (Rose, 1983). Similar to cultural studies' emphasis on the everyday experiences, feminist standpoint epistemologists also

see the world as problematic because traditional objectivity in research negated the legitimacy of alternative experiences and behaviors (Smith, 1987).

The question of objectivity is a characteristic postulate of feminist standpoint theory. Harding (1991) advocated that "strong objectivity" contrasts with value-free objectivity and encouraged that researchers should make no claim to universality. Haraway (1988) called this the "God trick," which subsequently rejects the idea that a researcher can view everything neutrally from the perspective of nowhere. Feminist standpoint researchers believe that researchers should acknowledge not only that there is a relationship between the participant and the researcher, but also that the relationship is acceptable to discuss, as long as the researcher is reflexive in reporting about the participants and the study. Likewise, Harding (1991) suggested that strong objectivity actually maximizes objectivity in allowing the researcher to garner more data about a participant's reality by relating to a participant on a very deep level and establishing a mutual trust with the participant. Therefore, in terms of sampling and collecting data, the researcher should start from the perspective of those marginalized by the dominant ideology and work outward, all the way to the perspective of the researcher (hooks, 1984). Feminist researchers have thus provided suggestions for how to conduct research from a feminist standpoint perspective, particularly for qualitative methods. For instance, Reinharz (1992) suggested the researcher focus less on getting the questions answered and more on allowing the participant to guide the interview, which enables the researcher to better understand the participant's perspective.

Cultural Studies Methodology

The cultural studies approach is a type of qualitative methodology that observes how cultural members use symbols, language, and texts to represent meaning (Potter, 1996). The genre of cultural studies has a less defined methodological standard because it draws from numerous disciplines, including sociology, anthropology, social psychology, humanities, and the like. Therefore, many methods are acceptable in the cultural studies' search for how cultures make meaning of the world around them. For example, Nelson et al. (1992) argued that all methods of discovery – including "textual analysis, semiotics, deconstruction, ethnography, interviews, phonemic analysis, psychoanalysis, rhizomatics, content analysis, survey research" (p. 2) – can be useful in learning about a culture.

Nelson et al. (1992) promoted the following characteristics common among cultural studies: although the genre looks for relationships between different cultural domains, the researcher examines all determinations; cultural studies are interested in the everyday of a culture as well as the ways "cultural practices speak to, of, and for" participants' lives (p. 11); and often, cultural studies assess the cultural relations, elements, meanings, and outcomes of those disempowered (and in power) within a society. Fiske (1992) considered the "distance" between high and low cultures, and he argued that cultural studies seek to understand not only the societal distance but the customs of everyday life as well, which he claimed have no distance (p. 154). These cultural studies traditions – particularly the last two characteristics of examining the everyday in conjunction with power relations from the vantage of those removed from political, societal, and economic privilege – resonates deeply with the philosophy I adopt in this study.

Cultural studies methods for current study. I recruited a cross-cultural sample of women to conduct focus groups and individual interviews about cervical cancer communication. I examined the *consumption* side of meaning making about cervical cancer communication by talking with consumers (women) in order to understand *consumption*. Finally, I asked women to invite friends and family into their homes for focus groups (women that are of the same racial/ethnic background) and provided them with (cervical cancer) media materials to discuss and evaluate.

In-Depth Interviewing

This study consisted of qualitative, in-depth, individual interviews as well as focus groups. I used semi-structured interviews, which is a tool used to learn about participants' feelings and experiences. The qualitative interview process seeks to know better the cultural communication methods, language, forms of actions between cultural players, and processes and thoughts that are otherwise hard to observe without intimate, in-depth, private, trusting conversation (Lindlof & Taylor, 2002).

Furthermore, the purpose of the semi-structured interview is to let the participant do the majority of the talking and the guiding of the conversation according to what she/he finds most important (H. J. Rubin & I. S. Rubin, 1995). This desire to reduce interviewer control and promote participant interaction during the interview reflects a feminist standpoint. Semi-structured interviews are appropriate for qualitative, cultural studies investigating women's meaning making because the technique is "consistent with many women's interest in avoiding control over others and developing a sense of connectedness with people" (Reinharz, 1992, p. 20). Finally, my purpose with research is to aid in empowering oppressed groups by providing a forum (my research) for which

women can speak; therefore, it may be important for women to speak with a woman researcher when providing intimate details because of issues of trust and gender equality (Grodin, 1991).

Focus Groups

The primary purpose of conducting focus groups is to achieve the "'chaining' or 'cascading' effect – talk links to, or tumbles of, the topics and expressions preceding it" (Lindlof & Taylor, 2002, p. 182). The researcher uses the dynamics of interaction to encourage deeper, constant discussion. Furthermore, the researcher often hopes participants like each other will feel trusting of the fellow participants so they will speak more intimately about the topic (Morgan, 1988). In audience reception studies, texts are often provided to the participants in order to catalyze their discussions about the topic (Lindlof & Taylor, 2002).

From a feminist perspective, focus groups are especially advantageous because there are more participants than the researcher; thus, power naturally shifts from the researcher to the participants, and participants are able to more freely discuss their concerns about the topic than having the group dominated by the researcher's interests (Wilkinson, 1998). Further benefits of feminist-driven focus groups include consciousness-raising about the topic (in this study's case, cervical cancer prevention); creating a collective self-empowerment; and allowing participants to actualize with their own languages and their personal frameworks (Wilkinson, 1998). Finally, focus groups help garner more intricate data because not only is the researcher able to study the interactions and languages among the women, but the women often aid in leading the

group by asking each other questions and pointing out each others' discrepancies that individuals may not notice alone (Wilkinson, 1998).

Participants

    Recruitment. I used purposive and convenience sampling for this study. Participants were identified through acquaintances and informal contacts. I began identifying women to interview by talking with a few informants in the areas in which I have access (Maryland, New York City, and Texas). The purpose of the informants was to provide me with information about the culture, environment, and people that I needed in order to gain access and build trust with the participants who I did not personally know (Lindlof & Taylor, 2002; H. J. Rubin & I. S. Rubin, 1995). Then, participants interviewed were asked for names of others who might be willing to participate in the focus groups. This recruitment technique is called snowball sampling because I built my sample based upon references of women I already interviewed (Lindlof & Taylor, 2002; Potter, 1996). In order to gather women for the focus groups, I found a woman from each race/ethnicity – through my personal and professional relationships – who was willing to invite several of her female family members and friends into her home for the group (using informant and snowball sampling techniques). The focus groups were held in two women's homes, and I provided refreshments and other supplies through a grant supplied from my university.

    Upon receiving potential participants' contact information, I invited the women in person, via letter, email, or by telephone, to participate, after which I explained the nature of the project and the procedures. I also informed them that their participation was voluntary. If they agreed to an individual interview, we decided on a place to meet, which

was always the participant's choice. If the women agreed to the focus groups, I provided

directions for each participant to the home provided for the group. Prior to each interview

and focus group, I presented each woman with a consent form, which contained

information about the study, participants' rights, and my contact information, which they

signed.

   Participants. A total of 24 women participated in the study. Fourteen women

participated in the focus groups – six in the focus group of Hispanic women and eight in

the White women focus group. Ten women were interviewed: three Hispanic women,

three African American women, three White women, and one Indian-American woman[2].

The women's ages ranged between 18 and 75 years old. The Hispanic focus group

consisted of women that were mostly older women, although there were a few women

who were in their late 20s and 30s. The majority of the participants were either in their

late teens or in their 20s. Several non-White women came from a variety of nationalities,

including Colombia, Ecuador, Haiti, Puerto Rico, India, and Mexico.

   The number of participants in each focus group reflected recommendations from

Lindlof and Taylor (2002), who suggested that six to 12 participants are optimal for a

focus group. If there are fewer participants than six, then the range of topics may be

smaller and the participants may become fatigued in terms of responding. If there are

more than 12 participants, there is the risk that some participants will not interact and that

some topics may not be discussed because conversations may linger too long.

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[2] I did not originally plan to use Indian-American women in the sample, simply due to lack of time and resources. However, a fellow graduate student told me a woman in her class was interested in being interviewed for the topic. Therefore, although I cannot generalize my findings to all Indian-American women, I can report how this one woman perceived cervical cancer communication in her particular cultural context.

Qualitative research suggests that a saturation point should be attempted, a technical postulate within grounded theory (Glaser & Strauss, 1967; Morgan, 1988). This concept refers to the point at which each single interview no longer adds unique information to the collection of data. According to H. J. Rubin and I. S. Rubin (1995), reaching this point can help the researcher gain completeness when each participant's responses are contributing significantly to answering the research question. As the authors put it, "what is important is not how many people you talked to, but whether the answer works" (p. 73). In my data collection, I realized at a certain point I was hearing considerably consistent answers from the women; thus, I decided I could stop interviewing because I had answered my research questions and was not finding any new, significant information.

Procedure

An interview guide helps the interviewer through the discussion and generally outlines the main points the interviewer would like to explore. The interview guide "consist[s] of groupings of topics and questions that the interviewer can ask in different ways for different participants" (Lindlof & Taylor, 2002, p. 195). The interview guide for this study was framed using three theoretical perspectives. First, I used the situational theory of publics to design questions to explore the level of involvement, constraint recognition, problem recognition, and information seeking behavior of the participants in order to situate them as certain types of publics of cervical cancer communication (Grunig & Hunt, 1984). Second, I used the cultural studies approach because it helped me develop questions about how the women made meaning of media and campaigns (Hall, 1997). Finally, I borrowed from Price (2002) who provided protocol development advice

about approaching African American women with health promotion messages and materials. I found her advice to be useful in developing questions to ask women from different racial and ethnic backgrounds that I may not have otherwise thought to ask about, such as cultural perspectives, family influences, and social support.

From previous experience with in-depth interviews, I have learned that people respond differently to questions through their individual styles regarding pace, order, control, patience, and interest. For example, some participants like to move quickly through the questions and some like to elaborate on each question. Therefore, I embedded probes in the guide, which I could choose to use in different places. I also found it important to remain flexible with the participants' styles and preferences to interview, which is why my interview guide has general, open-ended questions that can be easily transformed and re-ordered (please see Appendix for the interview guide).

I pre-tested my interview guide on three personal contacts by reading the questions aloud and asking them to provide brief responses. The purpose of this pre-test was to evaluate the flow of each question and the order of all the questions put together. I amended the guide based on the pre-test participants' suggestions about questions that sounded confusing or redundant.

I initiated the in-depth interviews with an open-ended question about the participant's perceptions of health and continued the interview asking open-ended questions about the general topic of cervical cancer. Although the topic is cervical cancer communication, the women had opportunities to discuss other major health concerns to them, if they felt other health topics were more important to discuss than cervical cancer communication. Interviewers are warned against asking leading questions because it can

implant the interviewer's bias and research objective into the participant's answers

(Emerson et al., 1995; Potter, 1996). However, Potter suggested that all answers should

be considered useable data, which is a philosophy I adopted in listening to women's

responses and exploring the details they told me were significant to them.

All individual and group interviews were conducted in person, and the majority of

the interviews were located in the women's homes, although some took place in their

workplaces. I interviewed the women where they felt most comfortable. The average

length for the focus groups was two hours, and the average length for the individual

interviews was one hour. Following each interview session, I asked the women if they

would like to pick the pseudonym with which I used in the report to identify them; most

women chose their own names. I assigned names to the other women in order to protect

their identities. I gave each woman a $15 incentive for her time, or she was given extra

credit in her introduction to communication course in which I arranged for undergraduate

students to receive instead of the $15 incentive (the choice of incentive was the

participants').

Data Analysis

After each interview session, I wrote my initial reactions and feelings into a

journal. In these journal entries, I wrote about the success of each interview, prevalent

themes I noticed, and any areas I needed to examine more closely or interview techniques

to improve upon for the next interview/focus group. These are "reflective remarks"

suggested by Miles and Huberman (1994) to "strengthen coding, in pointing to deeper or

underlying issues that deserve analytic attention" (p. 66). In the journal entries, I also

reflected upon my fears, judgments, stereotypes, and anxieties about the study, topic, or

participants. I used this as a way to clearly organize and understand my relationship to the study and the participants, and to ensure that participants had the room to speak for themselves instead of my leading their comments, a goal of feminist standpoint research (Reinharz, 1992).

Next, all audio tapes were transcribed. A service transcribed most of them, and I transcribed some. I inserted observer comments (OCs) (Miles & Huberman, 1994) throughout the transcripts, which are personal notes I made about emerging themes throughout the interview, linkages to other interviews, my interactions with the women, and ideas I had for future interviews or for my reporting.

Data analysis began at the transcriptions stage. I modeled data analysis after Miles and Huberman's (1994) approach and the grounded theory approach (Glaser & Strauss, 1967). During the transcription process, I used open-coding procedures to look for emerging themes. Then I used axial coding to determine how responses and themes related to each other as well as how the responses related to the variables and concepts informed by the literature review. Axial coding is part of the integration process of the grounded theory approach, and it uses codes that form linkages across disparate but meaningfully-similar codes in order to dwindle down the number of codes and understand overarching themes more easily (Lindlof & Taylor, 2002). I developed a coding system in order to reduce the ambiguity of the data collected and then combined the data to develop meta-themes in the participants' comments.

After I assigned codes to comments in the transcripts based on the themes found, I used the process suggested by Bogdan and Biklen (1998) to organize and categorize data by theme. I transferred all themes found in the transcripts into a word-processing

document. Each transcript had its own themes sheet. There were a significant amount of themes, so I grouped similar themes together according to general concepts. Then I printed out each transcript's themes sheet. I labeled each group of themes with the name of the interview and cut the sheets according to the groups.

Next I compiled all similar groups across participants' interviews/focus groups (for instance, all "constraints" groups of themes compiled together). I examined these themes carefully, looking for consistent ideas. I then made a coding scheme of colors and symbols, and I placed a symbol next to each instance of an important theme found in the transcripts to make sure the majority of the participants reflected similar ideas or feelings.

Although data gathered from interviews and focus groups produce different types of data, using the grounded theory approach (Glaser & Strauss, 1967) allows for the data derived from the different methods to be combined and compared together as one data set. The data from interviews is thick and rich in that the data is exclusive to one participant's perceptions without influence from other participants. However, in focus groups, the data obtained is less thick from individual participants but rather rich from a collective perspective. Individuals' perceptions could be biased because of other participants' influence, whereas in individual interviews, the information may be more independently pure. Therefore, I considered that the data may not be comparable. However, the constant comparison and integration methods of grounded theory approach allow for continuous evaluation of themes with each new set of data in order to ensure that the data are consistent with each other in order to posit emerging themes. Furthermore, gaps in understanding women's perceptions may occur in focus group dynamics, and the richness produced from interviews helps fill in those gaps.

These major themes are detailed in the Results section of this thesis. I referred to the transcripts for examples of the major themes and included quotes. I revisited the other slips of paper (groups) that were not used in order to double-check that no major themes were neglected. Finally, I reviewed once again each page of the transcripts to ensure I had not missed any major themes and to record any final thoughts that needed explanation in the results.

Validity and Reliability

Validity and reliability are debated in qualitative research. Reliability is the measure of how well the research instrument will conclude a study with the same results as others like it each time the study and instrument are used (Lindlof & Taylor, 2002). This means that each study is looking for something new. Therefore, results are highly unlikely to ever be replicated, because not only will each human provide different words and actions as data, but because that participant's as well as the interviewer's realities are always changing. Wolcott (2001a) referred to reliability in qualitative research as "an artifact" (p. 168).

Validity is the extent to which the research instrument accurately measures the value of the unit of study (Wolcott, 2001a), and external validity is the extent to which the results of a study can be generalized from the sample to a wider population (Lindlof & Taylor, 2002). The same problems of multiple realities, the nature of exploration versus the testing of existing theories, and researcher influence on the study and participants that arise when measuring reliability of a qualitative study also arise when measuring the validity of qualitative research. However, since validity considers that credibility and accuracy of the research instrument – and the research instrument in

qualitative research is the researcher rather than the questionnaire or experiment used in quantitative research (Cheney, 2000; McCracken, 1988) – then the validity of a qualitative study tests the "trustworthiness, credibility, dependability, and conformability" (Kvale, 1995, p. 21, citing Lincoln & Guba, 1985) of the researcher to study exactly what he/she means to study.

Therefore, the researcher should take as much effort as possible to display "craftsmanship" to the audience of the study, which is to continually check, question, and interpret the findings according to the theory used in the study (Kvale, 1995, p. 27). Kvale argued that the researcher should be aware of the validity question during each step of the research process, from the conceptualization of the research through to the reporting phase. Tactics he suggested include:

> …checking for representativeness and for research effects, triangulating, weighing the evidence, checking the meaning of outliers, using extreme cases, following up surprises, looking for negative evidence, making if-then tests, ruling out spurious relations, replicating a finding, checking out rival explanations, and getting feedback from informants (p. 27).

An important term in this collection of tactics is triangulation. In order to ensure the researcher is testing "a right interpretation" rather than "the right interpretation" (Lindlof & Taylor, 2002, p. 240), it can be essential for the researcher to strengthen his/her argument for interpretation (Potter, 1996) by using multiple sources, multiple methods, or multiple researchers to evaluate the unit of analysis (Lindlof & Taylor, 2002). Triangulation has the potential to reduce researcher bias that may influence the recruitment, collection, and analysis of data.

In my study, I considered craftsmanship in several ways. I wrote journal entries throughout my study in order to purge some of my biases toward the study, participants, and data. Writing my journal entries gave me the opportunity to identify and manage my feelings about the study in order to remain faithful to my commitment to validity. I also provided as many details as possible about my study so that readers will not have so many questions unanswered about my study. I triangulated my study by incorporating multiple methods and sources. I used multiple methods by conducting focus groups as well as one-on-one interviews. I talked with multiple sources, which are the audience participants – women from various racial and ethnic backgrounds. Finally, I conducted member checks throughout the study. Member checks are procedures to ask members – or participants – to review the researcher's end analysis to ensure the researcher accurately portrayed the participant's data in the report (Lindlof & Taylor, 2002, p. 242). I performed member checks in two ways: during the interviews/focus groups, I periodically "checked-in" with the participants to ensure I understood them correctly, and I recapped at the end what I believe I heard from them; I also chose a couple of participants to review my analysis before the final write-up for feedback about the accuracy of my reporting.

Reflexivity

As mentioned earlier, reflexivity is a marker of craftsmanship (Kvale, 1995), which shows the audience of a study that the work is credible because the research instrument is valid. In feminist research, Smith (1987) called for researchers to be highly reflexive in order to realistically understand the relationship of the interviewer to the study and to the participants. Wolcott (2001b) suggested beginning research reporting

with telling the reader how the researcher came to experience the problem in the study in order to help readers understand the necessity of the research.

I hope my personal account will connect readers to the experience of the study. I am a White woman in my mid-20s, pursuing a master's degree in communication with aspirations to advance the quality of women's health care in some way. I became interested in studying women's meaning making because I love qualitative interviewing. In previous experiences, I was exhilarated each time I interviewed a woman and she shared with me her health and emotional constraints as well as the joys of her life.

I became particularly interested in studying women of different racial and ethnic backgrounds for three reasons: (1) my mother is of Colombian ethnicity, and because I was never brought up with a very strong sense of my heritage, I am driven to learn more about a part of me that I have not known intimately; (2) in a study I conducted about Hispanic women's perceptions of diabetes campaigns, I interviewed a woman that hesitantly self-identified as "Hispanic." Instead she preferred to be self- and externally-labeled as "Texan" because she wanted to be integrated into the whole rather than separated as "Hispanic" when receiving health messages; and (3) I had previously conducted a literature review on the waves of feminism, and in it, two texts – Becky Thompson's essay, "Multiracial feminism: Recasting the chronology of second wave feminism" (2002), and Cherrie Moraga and Gloria Anzaldúa's *This bridge called my back: Writings by radical women of color* (1981) – especially humbled me by exposing me to perspectives of identity, relationships, and power that I have never recognized, and it sensitized me to issues outside of myself.

Finally, cancer is an important issue in my life – one that has taken many people I love and which I do not understand. Three of my five grandparents have passed away of cancer, in addition to a number of aunts, uncles, and friends who have struggled with the disease. My father has worked in a cancer research laboratory my whole life, and very recently, my stepmother developed leukemia, is now receiving chemotherapy, and living an entirely (unexpected) new life than the life she built for the first 48 years. Thus, I want to be a part of the struggle to end pain and suffering because of this disease.

Chapter 4 – Results

Overall, the women interviewed made meaning of cervical cancer communication in a number of ways relating to their recognition of cervical cancer as a problem and their involvement in cervical cancer as a health issue. Some women spoke of their constraints to complying with cervical cancer messages. The women made meaning through cultural concepts such as *lack of communication and promotion; grouping of women's issues together and their involvement as women; loss; control; privacy;* and *their self-images in the communication*.

The women were similar to each other in their use of mass media, such as the Internet, television, and women's and news magazines. When looking for health information on the Internet, almost all women said they used WebMD, Google, and other search engines for credible health information. Some women talked about television shows in which they had received health information, such as daytime and nighttime soap operas, reality shows, *Oprah*, *Dr. Phil*, MTV, and Court TV. Other communication venues women used included someone in their families that worked in the medical and nursing fields, health books, sororities, and their jobs (for example, one woman works for an empowerment group for girls; another is a graduate student that operates a Web site about sexual health for Hispanic teens and young adults).

RQ1: How do women from different racial and ethnic backgrounds recognize the

problem of cervical cancer, perceive constraints to comply with cervical cancer

messages, and perceive their level of involvement?

Problem Recognition

Recall of messages. Although all women said they were aware of cervical cancer, the large majority of the women had never seen messages about cervical cancer. If they had, they vaguely recalled what they had seen but they could not describe any particular slogan, image, or message. Several women said they had most likely learned about cervical cancer in a health class from high school or college, from a poster or brochure at the health center at their university, or through a health book they consulted for various health issues.

There were exceptions, however. A few women recalled cervical cancer communication because someone close to them either had cervical cancer at one point or had HPV (and, therefore, had to be checked for cervical cancer development frequently). One woman, Nicole, a White woman in her late 20s, reported that she had HPV, which is why she offered to be interviewed after I told her about my thesis topic (no other woman I interviewed reported having HPV or cervical cancer). Additionally, several women talked about having had abnormal Pap smears, and some said they knew it was related to cervical cancer, whereas others said they only learned about the link in the interviews/focus groups.

Knowledge of cervical cancer. When I asked women what came to their minds when they heard about cervical cancer, most women described their understanding of the causes, effects, and detection methods. In many of the discussions, I perceived a significant lack of understanding or misunderstanding about the nature of cervical cancer. For instance, several women said that they did not know that the Pap smear was the detection method for cervical cancer. Amee, an Indian college student, said that when the university health center gave her information at freshman orientation, she realized Pap

smears were used to test for cervical cancer, whereas "before that, I had no idea what they were." Furthermore, many women learned during the focus groups and interviews that HPV is a leading cause of cervical cancer. Regarding misunderstandings, some women believed that an abnormal menstrual period was a signal of cervical cancer, and other women believed HPV and herpes were the same STD. In the White focus group, when I asked the women what they thought about cervical cancer, the women reflected this lack of knowledge:

Anne: That I don't know anything about it.

Candy: Pap smears.

Penelope: Yeah, like an abnormal Pap smear.

Candy: Does it check for cervical cancer? I get them, I go to the doctor, what's it for? No one knows.

Anne: You're just told you have to do it.

Candy: That's the only reason I go.

There were no patterns of misunderstanding according to race ethnicity, or education. The closest to distinguishing women who I perceived as more knowledgeable of cervical cancer than those with misunderstandings was by age: the women who were in their 30s and older seemed more knowledgeable about cervical cancer, whereas the younger women held the least amount of knowledge about cervical cancer. The older women were also the ones that recalled seeing, hearing, or experiencing more communication about cervical cancer than the younger women. Not surprisingly, the woman with the most accurate knowledge about cervical cancer was Nicole, the woman who reported having HPV and explained her frequent (every three months) Pap smears.

Obligation – as noted in the previous dialogue – was one reason women discussed for getting Pap smears. Several young women said they did not know that they were being tested for cervical cancer when they had their Pap tests conducted but that they always had their Pap smears because they were told to or they believed they were supposed to have them conducted. Some, however, and particularly among the younger women, said they were getting their Pap smears done in order to receive a refill on their contraceptive prescription from their gynecologist. In wondering about how people with no insurance get their Pap smears, Anne, a White woman from the focus group, asked, "do people get annuals who aren't on birth control, because that would be one reason you do it is to get refills, right?" Similarly, Veronica from the White focus group agreed:

> I do my annual, and I feel like that's the minimum I need to do. But I do that because of my [contraceptive] refill, and I'm glad that they make my refill on an annual basis because at school – man, it was like a dollar a pack, and my girlfriend gave me bags of the stuff. So I didn't have to go for a long time.

Lack of communication and promotion. By a large majority, the women said they had not seen any messages about cervical cancer. This was a reason many women – particularly the younger women – cited for not feeling involved with the disease. Specifically, many women talked about their gynecologists' lack of communication about cervical cancer; the uncertainty women felt they experienced regarding information they perceived to be about cervical cancer; the lack of promotion of cervical cancer; and the overshadowing promotion of breast cancer to women.

As mentioned earlier, many young women said they did not realize they were being tested for cervical cancer when they had their Pap tests conducted. These White

women discussed that their doctors do not tell them they are being tested for cervical cancer while the exam is being performed:

Jen: Is that what you're thinking, that no one knows what the Pap smear is for?

Candy: People go, really? That's what a Pap smear is for? I know I get them, but why?

Veronica: I think they make you get them just to make you embarrassed.

Lola: What is that thing?

Veronica: Yeah, I didn't know what that was for. And they do that every time. Don't you do it annually?

Olivia: That's just the cotton swab, right? They just take a little scrape…

Concurrently, some women did not know what questions to ask their doctors about their Pap tests. Penelope, a White woman in her early 20s, said that she had a communicative gynecologist that explained the purpose of the Pap test; however, when her doctor called her in for a follow-up test because she had had an abnormal Pap, she "didn't really know much more than that. I guess I didn't really think to ask, because I still don't really know." This perception was related with several women's feelings of intimidation in their doctors' offices. Some women attributed this fear of asking their doctors questions due to their feelings of being "rushed" during their visits. Other women said they were intimidated to seek information in doctors' offices – such as picking up a brochure about STDs – because of what other, older patients may think of them. Finally, one White woman discussed her feelings of distrust after her gynecologist checked her for rectal cancer without informing her what she was performing:

…she didn't say…she wasn't informative. Now, if she had said, we're going to have to do this, this might be cold, and I was like, god! Yeah, cold! And many other things…wrong. You know it's like, they should just tell you why they are doing this. I mean, I was ok the whole first time I got a Pap smear because I had talked to my girlfriends, like, what are they going to do, I just want to know. But something that you are not expecting, it kind of made me feel like, oh, I can't trust her as much…she just slipped her finger up my butt.

Connected to this lack of awareness were feelings of uncertainty about the nature of cervical cancer prevention, detection, and treatment. One younger White woman talked about her confusion over her abnormal Pap smear and her resultant cervical biopsy because the doctors "don't tell you what it's from" or "they didn't tell me enough about it," and she did not understand why the doctor "couldn't have just done a third Pap and not cut a part off?" Similarly, two women from the White focus group explained their confusion about the cause of abnormal Paps, and one used her knowledge of skin cancer prevention as a benchmark for trying to find an answer to her question of how to prevent cervical cancer:

> Penelope: I've had an abnormal Pap smear. I had one a couple of years ago, and since then, they have all been normal, so who knows really what it was? It's always stuck in my mind, why the hell was it abnormal? Is it something that is going to show up again someday? I think there's a lot of worry associated with it, and I think that just stems from not really knowing what the causes of an abnormal Pap are.

Anne: On that note, one of the girls said earlier our health concern is skin cancer. But we all know is how you get skin cancer and what you do to prevent it. But I don't know how you get cervical cancer, if you can prevent it…

Woman asked questions during the interviews to inquire about the communication and promotion surrounding cervical cancer, such as, "Is there a cervical cancer foundation? Because I haven't heard of one," "If it's a big deal, and it's something that is affecting a lot of people or on the rise, then why isn't more money being spent on it?" and, "You know like Sting and the rainforest or whatever, so like I know there is a lot stars connected to different things, but there is not like a Michael J. Fox for cervical cancer or whatever." Carolina, a Hispanic woman in college, did not feel particularly affected because she had not experienced any similar gynecological problems as well as she did not know about cervical cancer and perceived that "no one is taking action":

Because I don't know anything about it. No one has really said anything, so if they had more of promotion, almost as much as breast cancer, then I would take probably more interest in it. It's unimportant and it's not targeted to me. Like if women – you know, older women – like you said, who have hysterectomies know more about it, it's because it's geared towards them because they've already come close to that area. Like, me, not so much because I don't know because I've never had anything remotely close to any of that, so it wouldn't be anything of my concern.

In fact, some of the women felt surprised at what information they were not aware of regarding cervical cancer but that they learned through the interviews and focus groups:

Anne: …now that I am reading all this HPV…all of the sudden I'm like, whoa! HPV…STD…then cervical cancer. Not straight to cervical cancer. We're all saying that prevention is the Pap smear, but it's like wait, the prevention is the whole STD…

Veronica: I think for prevention, I'm still not…if we're saying that HPV would be cervical cancer, and that's the number one cause of it, then we're back onto the STD prevention type stuff. Before this, I didn't have that connection. I thought that if I've got the bad genes, I'm going to get cervical cancer.

Monique: Yeah, like I don't connect cancer with STDs. I never did.

Several women did not believe cervical cancer to be a high priority, but rather, breast cancer was a major women's health concern because of the large extent of media coverage women said they received about breast cancer. Ximena from the Hispanic focus group said that breast cancer was a health concern for her "because you hear about it so much," and Penelope from the White focus group said the Susan G. Komen Breast Cancer Foundation "just infiltrates every type of media." Veronica pointed to the symbols she remembers seeing regarding breast cancer, one of her major health concerns: "We've seen the breast cancer – the pink stuff everywhere – so of course you are going to think about that more, because, you like see it." Lisa – a White woman in her late 20s whose mother had breast cancer and who volunteers for the Komen Foundation regularly – compared her exposure to cervical cancer to that of breast cancer:

I doubt that I've ever read an article about cervical cancer that was like the ones that I might see on breast cancer, which would have a person or whatever and they would talk about it and they would say, here are five things you should do.

Like I've never seen an article about cervical cancer that said these are five things you should do so, therefore – I   had never received those messages I guess.

Similarly, Angela, an African American woman in her mid-20s, explained that as a woman, she has multiple health issues to worry about, and she has trouble negotiating which to address first. She talked about her concerns about concurrent problems like endometriosis, breast cancer, and cervical cancer, which are major health concerns in addition to HIV, STDs, heart disease, diabetes, and lupus. Angela talked about trying to negotiate concurrent health threats, such as cervical cancer, endometriosis, and breast cancer, and that she has to decide which is the greater of the three that she needs to worry about at a particular time.

Constraint Recognition

Lack of money/insurance. Although some women were not clear about whether they obtain regular Pap tests, some cited reasons why they would not be able to obtain them or they do not seek information about cervical cancer. Fallulah, a woman from the White focus group, said it was a lack of money, a lack of insurance, and laziness that caused her to delay having her exam:

Honestly, and this is a personality thing on my part, but I don't do most things kind of out of laziness. Maybe it's the invincibility thing, and I am going to be really honest in that I haven't gotten my annual this year, and I am going to call tomorrow. But, it's like, I could spend the $25 and go do the whole thing, or I could just not deal with it. It goes in my head and out, and I don't think about it.

Privacy. The sensitivity of privacy emerged as a reason women did not seek information about cervical cancer from or around other people. Some women were

uncomfortable talking to others about (a) Pap smears, (b) STDs, or their sexual experiences. Others were generally embarrassed to discuss (c) women's health topics. Some were uncomfortable during their Pap smears and did not feel secure asking questions of the (d) doctor during the exam or afterwards. A few women even attributed this sensitivity to feeling comfortable and the need for privacy to the reason they did not understand health issues like cervical cancer more completely.

More young women talked about discomfort of having their Pap smears performed than did older women. One women mentioned the discomfort of the "footholders" during the exam; another woman suggested that daytime talk shows should feature women talking about obtaining their Pap tests in order to encourage women to get theirs done: "But just having girls talk about, oh I had to go, it was so embarrassing, or whatever, but on like a regular TV show." Olivia, a White woman in her early 20s, said that she would like her gynecologist to talk to her about the Pap test and tell her she is testing her for cervical cancer while she is performing it: "First of all, it would fill all the dead silence whenever they are looking at your genitals. And then also it would make you more comfortable."

Concerning seeking information for STDs, the women from the White focus group expressed several times the embarrassment and discomfort they associated with having an STD and not wanting to discuss it with other people. To this point, Penelope projected that in conjunction with embarrassment, people with STDs may experience denial as well "and just…not accepting it enough – that you don't want to believe that it's gonna affect you or your relationships with other people, so you just don't even talk about it and act as if it doesn't affect you." Another woman in that group said that she

knew the statistics of STDs on college campuses, and during her sorority years, she did not know anyone with any STD: "Basically, that's not what the statistics say. So, I know that people are too embarrassed to say that."

Some women talked about information sources they use in private that they feel they could consult about which they would not feel comfortable asking another person. Many younger women talked about their preference to use the doctors and nurses at their universities' health centers for information about sex, STDs, and contraceptives while they were in college because there was a level of anonymity to these venues versus going to their oftentimes family doctors or doctors they had seen for a while and knew they would see again. It made many of the young women comfortable to know that they could tell the university health center practitioners anything, and then they may never see that person again. Furthermore, the women preferred these venues as well because they perceived these practitioners to understand the women's particular health and social situations better than other practitioners. Penelope said that the health center practitioners expected students to speak openly about sexual experiences:

> …expected us to talk about…like, be honest about being sexually active. It was really easy to do so, because that was kind of the expectation, and you know that the person they just saw before has probably had sex too, and probably just told them. So, it's just kind of an easier thing to talk about, and that obviously makes it, more comfortable.

Likewise, Carolina explained that she would rather the information find her than her having to seek information about topics like cervical cancer because then "you're not the only one or you don't have to have the guts to go up and pick up a pamphlet on this."

Media venues women spoke about that they would feel comfortable seeking information about privately were magazines, the Internet, and television.

Specifically, Amee described the Indian culture as "so conservative," and she said that issues like contraceptives, genitals, sex, cervical cancer, and STDs are things that are "not talked about…not something that people recognize. Women would not talk about it. My mom would never talk about it with me or I would never talk about it with any women from my culture besides my friends." She said health issues "like diabetes [are] easier to talk about, that's basically a normal thing. But anything personal, getting down to a personal level, that's just really hard to bring out in the open." Amee said that if she were looking for information about cervical cancer or other personal topics, she would consult a professional doctor, outside of her culture, and most likely a female doctor.

Lastly, part of this discomfort – the younger women attributed – was due to a lack of security they felt with their doctors in general, either because of the age, gender, acquaintanceship with, or bedside manner of their gynecologists. A few younger women said they went to family doctors still and thus, they were not comfortable talking about sexual or women's issues with them. Also, several women expressed their frustration and lack of confidence in their doctors when they felt rushed, and instead, they felt more comfortable talking with the nurses because "I don't feel like I am wasting the nurse's time." Finally, the gender of their doctor often impacted whether they felt comfortable talking about women's issues. For example, Monique – who still sees her family doctor – said she has been going to this doctor since she was "this small…he treats me like his daughter…it's kind of weird because he will say things to me, oh, like you're getting a little fat." As a result, Monique perceives a "whole intimidation and weird relationship

with the doctor" and thus will not address women's issues with him. Even in the brochure communication, the younger White women were sensitive to the images of a drawing of a male doctor performing a Pap test on a woman:

Fallulah: I could do without this.

Anne: What?

Fallulah: The tanned man with the telescope, looking right into your vagina.

Veronica: Make it a woman, for goodness sake.

Anne: NO WAY!

Candy: I just can't take that seriously. I don't even want to read it because I'm so distracted by the picture.

Monique: Beam of light. That's my favorite part…right in the middle.

Level of Involvement

Almost every woman said that she never actively searches for information about cervical cancer. The reasons women did not search for information is because they generally feel unaffected by the risk of cervical cancer because they already regularly obtain Pap tests. Women did not feel involved enough to seek information for the main reasons of lack of promotion, age, and no previous gynecological problems (these themes will be elaborated on later in this section). First, most women held the perception that cervical cancer is not widely promoted in the media and therefore, it must not be a significant health risk. Second, most young women felt cervical cancer affects older women, not younger women. When I asked Carolina the extent to which she felt the messages in the brochures targeted her, she explained her perceptions of both of these reasons for feeling uninvolved:

I feel like not so much because I'm young. I think to a different age group, yes, it would target them. To me not so much just because I don't know anything about it. Just because these people on these pamphlets don't look my age and I don't know anything about it.

Finally, women believed they were either more involved with other women's health issues or unaffected because they had never experienced another gynecological problem. For example, Christine, an African American woman in her late 20s, was very concerned with her chronic endometriosis that she did not think to search for information about cervical cancer. Likewise, Lisa, a White woman, was mostly involved with volunteerism and prevention of breast cancer because her mother had breast cancer. Similarly, Candy, a White woman in her early 20s, felt she did not seek information because she had not received any signals telling her something was wrong:

And I think a lot of it is until something does go wrong, you really don't know what to ask because you just take it for what it is. So you're like, OK, everything's great…I don't know what's going on, but I know it's going good!…I have been really blessed that I have had normal Pap smears, I've been normal with all that stuff, so I don't really know much about it because I haven't asked because I'm like, check, good! See you next year. That's partly my fault because I don't seek answers, but I don't really have any questions because I was healthy.

The only woman that talked about ever actively seeking information for cervical cancer was Nicole because she had been diagnosed as having HPV. No other women said they ever searched for it for themselves.

RQ2: What factors contribute to the ways women of different racial and ethnic backgrounds make meaning of cervical cancer messages in media?

Grouping of Women's Issues

Most of the women interviewed seemed to make meaning about cervical cancer through the lens of other women's issues. These women seemed to group all women's health issues together and approach their gynecological health holistically. For example, in a discussion of a particular women's disease she learned about because she did a project on it (but of which she could not remember the name), Amee explained how she connected cervical cancer when she thought of this disease, which she learned meant women could not have babies any longer, they received surgeries as treatment, and they experience "pain for most of their life, and when I think of cervical cancer, I somehow think of that…I know there's different things, but they all fit into one category for me."

Association to breast cancer. Similar to the larger promotion of breast cancer discussed before, women also associated cervical cancer with breast cancer, even though they did not think about cervical cancer before the focus groups/interviews. When I asked Carolina what she thinks about when I mention cervical cancer, she said breast cancer was foremost in her mind:

I just – cancer in general, like not even the cervical part really pays attention to me. Just when somebody says cancer I automatically think actually breast cancer because it is the most advertised predominant, talked about and in my mind, the way that I perceive it, it's probably the most predominant cancer. It might not be, but that's the way that I see it.

Women also often asked me – and in the focus groups, they asked each other – questions in order to clarify their understandings of cervical cancer and the cervix in relation to other information they had about women's health. When I spoke with Heather, a White woman in college, about her major health concerns and about her perceptions of cervical cancer, she mentioned, "breast cancer, as a woman, definitely" and used other women's health issues she was aware of to connect herself to cervical cancer:

> Heather: I don't know that much about it because I just know about breast cancer. That's all I ever hear about. I mean can I ask – cervical cancer isn't that – when you look at a Pap smear is that when they test you for it?
>
> Jen: Yes.
>
> Heather: That's like the only knowledge I have about it then is from getting Pap smears…I don't think I know anyone who has had it. I'm trying to think. I knew someone who had to get their ovaries and everything removed, but is that related to cervical cancer at all or no?
>
> Jen: Well, it's all part of the female reproductive system, but the cervix and the ovaries are different.
>
> Heather: Well, I honestly – breast cancer. If I think of cancer and in women I think of breast cancer.

Personal relationships with women with health problems. Often times, the women also made meaning of cervical cancer through the women in their lives who had experienced some type of reproductive cancer or women's cancer as well as other types of cancers that were of concern to them. For example, Liz, an African American woman in her late 20s, used her friends' gynecological problems as a vehicle for her

understanding of cervical cancer: "I think it's a cancer of the cervix, and I kind of know what that means, but other than that – well two of my girlfriends have fallopian tube problems, so they've explained – so that's what it means to me." Likewise, women situated their understanding of cervical cancer through their understandings of other cancers. For example, in a discussion about their understandings of the function of the cervix, Veronica related the functioning of her cervix to the functioning of her skin: "In terms of skin cancer, well, I need my skin. Cervical cancer – I don't know what I need that for."

Menstrual cycle. The women in the Hispanic focus group made meaning of cervical cancer through their perceptions of the proper functioning of their menstrual cycles. When the women talked about breast cancer and performing breast self-exams, Nadia, a Hispanic woman in her late 30s, said she does not perform them but her period signals to her any cervical problems: "I don't want to get stressed out. It is because of the stress. With the cervix cancer, you have your period every month, and if one month, your period is something different, then something is going on." Ximena, another woman in the group, had two friends with cervical cancer, and she related their cancer to their irregular periods:

> No, it became irregular. And I have another girlfriend – actually, that was the first time that I heard of cervical cancer. It was like maybe 10 years ago. And she went for her regular check-up and they found in her – I guess when they did her culture, something came back abnormal – and then they detected it.

Sexually transmitted diseases. Several of the younger women also said they were concerned about STDs, and as they learned that HPV – an STD – is related to cervical

cancer, they began to tie their perceptions of STDs to cervical cancer. Christine said she

thinks of HPV and multiple sexual partners when she thinks of cervical cancer. In the

same vein, STDs are a major health concern for Heather – an 18-year old, White college

freshman. She felt the cervical cancer messages were not targeted to her because they

picture older women on the brochures and that they did not address her concerns about

HPV and the connection of HPV to cervical cancer. She provided a messaging

suggestion: "I guess for me I would try to kind of use the HPV maybe because I feel like

that's kind of more of the threat to me that it could turn into cervical cancer. That's what

I'm worried about right now. At the age of 18 I just don't worry about coming down with

cancer though." Similarly, two African American women mentioned that HIV was a

major health concern for them, which was a disease they associated with control and

personal responsibility (to be discussed later). They transposed these meanings onto HPV

and cervical cancer.

Women as target audience. Some women made meaning of cervical cancer

because women have cervixes, and therefore, they felt involved in the threat of cancer of

the cervix. When I asked the Hispanic focus group women to what extent their think they

perceived cervical cancer differently than women who were not Hispanic, Malena said

that she did not think there was a difference "because the message is the same…because

we are all women, and we all have that issue to deal with, as women." Malena also felt

that "no one's free from [getting cervical cancer]." To that same question posed to the

White focus group, Anne responded similarly: "A cervix is a cervix, no matter what race

you are. Biologically, it's got to be all the same, right?" Finally, several women said that

the images of women in the pictures in the brochures related to them because of their

gender. Lisa, for instance, said, "the fact that I'm a woman…I can't think of a way that it could be more targeted towards me unless it was like [city where she lives] women speaking about cervical cancer."

Loss

The loss of something important to women emerged as a major theme when women expressed their perceptions and feelings surrounding cervical cancer. Interestingly, very few women discussed cervical cancer in terms of death, although the focus group of White women did express surprise in the numbers of new cases and deaths from cervical cancer they read about in the brochures. Rather, women talked about the loss of the ability to have children; the loss of female body parts and womanhood; the loss of sexuality; the loss of a relationship status; the loss of positive social judgment due to stigma; and the loss of normalcy.

Inability to have children. This was the most prominent loss theme across the women in this study. During almost every interview session, women either talked about their personal perceptions of not being able to have children – and the fear they felt based on that perception – or the perceptions a friend had who may have experienced cervical cancer, abnormal Pap tests, or other similar gynecological issues. Amee pointed out that her perceptions of the loss of the ability to have children stemmed from her grouping of all women's issues together, and a couple of women talked about limited options as a result of cervical cancer and even STD infection. Liz, an African American woman, for instance, related cervical cancer immediately to her friends' fallopian tube problems and their doctors telling them they may not be able to conceive children, so they should start

trying to conceive now rather than waiting until they were 35: "So, imagine you're 25 and that's your options. I think it's really harsh and so it was really hard on them."

This loss was particularly poignant for the focus group of White women, who were mostly recently graduated from college. A few women were married, and most others had significant, long-term partners. During a discussion about the stigma of STDs and HPV, one woman expressed the childlessness stigma she felt toward cervical cancer:

Fallulah: On a totally different note, and not a sexual stigma, but I think of people having cervical cancer as being relatively younger, I guess.

Penelope: Like younger than us?

Fallulah: No, like as in you get cervical cancer, and therefore, you cannot have babies.

Veronica: Not like after you have kids…?

Fallulah: Yeah. I guess that's the affiliation that I have: cervical cancer and babies. So the stigma would be that could not bear children, let us all feel so bad for you.

Jen: Why do you guys associate cervical cancer with not being able to have kids?

Anne: Because it's part of the female body, and I associate anything like that with the female body.

During a discussion about someone's friend who was told she could not have children because of a form of gynecological cancer, Penelope commented, "that's like the scariest thing in my life out of all health…not being able to have kids." Several women agreed with her about that fear. In turn, the women almost unanimously suggested that messages targeted to women like them about cervical cancer and STDs should contain

messages about potential childlessness. Lola recommended a message: "You won't be able to have babies if you get cervical cancer, so go get your annual."

Loss of womanhood and female organs. Women's feelings of a loss of womanhood were closely related to their fears that cervical cancer meant they could not have children. Angela described her similar perception of cervical cancer as loss of womanhood, having children, and the commonalities with menopause: "And then there's a loss of your own womanhood, if you can't have children, if you want to have children, maybe you feel that, I can't reproduce anymore. I think it's the same thing with menopause." But some women expressed a perception of actually losing their body parts. When I asked the Hispanic focus group what automatically pops into their heads when they heard the words cervical cancer, a few women talked about the removal of organs:

Pilar: Will they have to remove everything?

Nadia: And then I think the uterus, everything inside. And then I believe you're going to have to take some…

Loss of sexuality. Almost simultaneously with the loss of womanhood, women talked about the loss of sexuality and the loss of having others desire someone with cervical cancer, sexually or romantically. When I asked Nicole how she felt when she found out she had HPV, she said she "cried every night…I felt no one is going to want to be with me. I'm a little bit more comfortable now, but if I enter into a relationship, I don't know how I am going to tell the person." Pilar from the Hispanic focus group had had a hysterectomy, and she said people "think that the woman changed because the uterus was removed. No more sex in life. It's not true." To this comment, Ximena believed men

think this, and Nadia responded that even "women worry about not having sex." Finally, Angela also talked about a loss of sexuality and of partners:

I'll just put this out there: no one wants to fuck you. No one wants to have sex with you. A man would not want to – a man or a woman would say, I'm not putting any part of my body close to your because you have X, and I could possibly catch that. Even though you can't, somebody would say, I might be able to get contaminated by what you have. And there's that risk of saying, I would be undesirable to people if they knew that I have this. So there's that loss of sexuality and there's that loss of desirability to the other sex or to whoever you are usually…you can't have intimate relationships with another person.

Losing relationship status. In addition to the loss of sexuality and sexual partners, women also perceived this loss to be linked with losing some status in the romantic relationship a woman has with another person. For example, Nadia from the Hispanic focus group said that a woman not being able to have sex is also "worrying about not being able to please your husband." Veronica, a White woman in her early 20s, also experienced a threat to her marriage when she received abnormal Pap results: "Then [husband] was like, can you have babies or not? And I was like, yeah, I can have babies. We're like, all right, we're still on for the marriage." A woman also mentioned telling someone about having an STD "is almost a death sentence for your relationship, the minute it leaves your lips." For Heather, a White woman in college, her major health concern is STDs because of her perception that she is at high risk by being on a college campus. She also explained that when a friend contracted HPV, her awareness was

heightened not only about STDs and HPV but about associated threats to monogamous relationships:

It was like a light bulb – like it made me realize that because she had just been with her boyfriend…and he cheated on her and it just made you realize that you have no idea – that's why I said STD's is a health concern of mine. They're just everywhere. People are not always that honest. It just made me realize that I need to be really, really careful.

Social judgment/Stigma. The stigma related with cervical cancer – due to the fact that it can be caused by HPV, an STD – was important for the focus group of White women. They related STD infection to an overall loss of positive social judgment. For example, Fallulah, a White woman from the focus group, called having an STD "just a nail in the coffin," and Lola, another White woman, commented that, "you're plagued now." In a discussion, the women related the stigma of cervical cancer to the stigma of STDs:

Anne: Is [cervical cancer] contracted?

Penelope: Well, some STDs lead to it. HPV. So I think, in that sense, I don't think there is such a commonly known stigma with cervical cancer, but I know, and maybe some people know, that you get HPV, and it could lead to that.

Candy: And it's like, you don't want to be under a stereotype like, oh, I have it, and then someone placing a label of you having an STD. Because, you know, maybe someone is only educated on the fact that you could get it from HPV.

Loss of normalcy. Women who had experienced the process of following up on "abnormal" Pap tests expressed similar sentiments of the loss of normalcy. For example,

when Angela, an African American woman, was told that she had ascus cells in her Pap smear, she felt scared and unsure: "I just had tears in my eyes. I was thinking, I just don't know what I am going to do…this is so scary. It was so strange. I was just like, I don't know what I'm going to do." Similarly, the women in the White focus group talked about how their biopsies made them physically feel:

> Penelope: [Picture of a Pap test] makes me skirmy, y'all.
>
> Olivia: Really? Why?
>
> Penelope: I don't know. It just does. You know what I think it is? I think it's like when we were talking about earlier, how Veronica, you and I had like, an abnormal Pap, or whatever. Having to have a biopsy, and remembering how that felt, is a little…
>
> Veronica: It's stressful. And that, it kind of like pinched. Eww.
>
> Penelope: Yes! Oohh. It just grosses me out.

Finally, Liz, an African American woman, mentioned several times that she perceives problems like cervical cancer and other types of cancers as "your body turning against you." I asked her what she thinks cervical cancer means to her friends and family, and she explained the loss of normalcy her friends with fallopian tube problems felt:

> For my friends, it's not a death sentence, but it's not something – it's kind of like a tragedy. It's kind of like their bodies are turning on them. For them it was weird. It is something that we're not young anymore. It's kind of strange. I don't know of anybody we knew growing up who had any form of cancer. And suddenly they did and they're bodies were no longer their own, and it

didn't function the way we were always taught it was going to function. I don't think it means anything for me.

Control

Active vs. passive diseases. Some women believed cervical cancer to be a controllable disease because it could be caused by an STD, and they believed they could actively manage contracting an STD. Anne, for example, believed cervical cancer to be a controllable disease: "I can say the difference is that if you are educated and responsible, you may not get an STD, and you may not get cervical cancer, but if you're educated and responsible, you may still get breast cancer." In comparison, Liz felt that cervical cancer was not an "active disease":

I feel like [cervical cancer] couldn't happen to me. It's like this is not an active disease, nothing that you could bring to yourself like HIV, you know you have to be kind of irresponsible in your behaviors for that to happen, but if you are, that can happen. This is something like something that can happen and you don't know…From what I understand about cancer in general, it's your cells turning on you for no particular reason. It's not like you have control over that. And I think in essence my mind is like well, this is something I can't control, so I'm not going to worry about it.

Moral systems. Based on the fact that cervical cancer can be caused by an STD, several women viewed cervical cancer as a consequence in their system of morals. For example, Christine, an African American woman in her late 20s, said that she views health through values, and thus, she perceives cervical cancer to be related to HPV and having multiple sexual partners, a reason she does not see herself at risk for the disease.

Similarly, when Angela learned of her abnormal Pap test results, she wondered if she had done something wrong to deserve this consequence:

> I avoid thinking about this, but it was in the back of my mind, like, oh my god, something is wrong with you. Like, my thing is – I don't have sex, I don't drink, I don't do anything bad, I'm a good person…why the hell is this happening to me? What's wrong with you? I was beating myself up, why is this happening to me? Like it's just a test that happens. Who knows why it happens. It just occurs, like, why did my cells do that? I guess it just happens. I didn't search out information like I did the last time, I don't know why.

> *Empowerment.* Empowerment was mentioned in some interviews as a response to women's perceptions of control over cervical cancer. Many women talked about the need to educate themselves about health threats and prevention and detection methods in order to remain healthy. Liz said that when she receives messages about health threats, her first reaction is denial that she is affected. Then she thinks, "that's silly, knowledge is power, and if you gain it, you have a little bit more control over what is happening to you." When Gabriela, a Hispanic woman in her early 30s, read the brochures, she appreciated the ones that explained what a patient needs to know regarding the procedures involved with the Pap smear:

> And when they include how to read a Pap smear, that's a little bit empowering, because sometimes you undergo a Pap smear and you have no idea. They won't call you…You have no idea what they're doing there. They're taking a swab and – you know. So, just knowing or least someone telling you this is what is going on and this is what is normal, and this is what is abnormal. You feel a little bit

relieved. You feel like you have more information that at least you can use and you can understand what is going on when you go to your – you feel a little bit more control over your health.

Detection difficulty. On the other hand, some women felt developing cervical cancer was hard to control because of the difficulty in understanding the cervix (because of its limited visibility to lay women); the difficulty in detecting HPV; and in other cases, the detection problems of mammograms – an unrelated problem for cervical cancer but a related problem for some women's faith in cancer detection practices. Women seemed to express that these limited visibilities led to a general uncertainty many women expressed not only about cervical cancer and its relation to HPV and the Pap test but a larger ambiguity about controlling their health as a woman. For example, Lisa said she liked the diagrams of the cervix in the brochures because "it's not a place you can really see." Similarly, the focus group of White women attributed their lack of understanding about the function of the cervix because of their inability to see the cervix:

Veronica: I don't even know what the cervix does. I know it just opens up when it's time to deliver a baby, but other than that, it's functions…

Lola: Is the cervix what dilates?

Veronica: Yeah. That's the part that controls where your uterus comes into your vaginal canal…Yeah, because all you see are pictures – you've never had a friend that's like, all right, why don't you just look up there and see what it's like.

Monique: Yeah, because no mirror is going to show you a cervix.

These women viewed this lack of detection more broadly than protecting themselves from being at higher risk for cervical cancer. In a discussion about whether

the women would obtain STD tests from their gynecologists if asked, the women

contemplated their old perceptions of STDs to their changed attitudes, based on the day's

discussion of cervical cancer:

Olivia: Maybe if I were trying to be really careful, I'd be like, well, I've been with

the same guy since the last time, or I haven't had sex since the last time, and they

were like, well, you don't have to be, I'd be like, ok, let's do it. You never know.

Veronica: And things can lie dormant for months, and you would never know it.

Olivia: I guess I'm scared that something would pop up and I would be like,

where'd that come from?

Anne: More of the, you may not see the symptoms, it may be dormant, because I

had no idea. Everyone knows, ok, you've got big old warts, stay away from you.

Concerning breast cancer, the group of Hispanic women talked extensively about

their concern over information they had received about failures of mammograms to detect

cancerous lumps in relatives' breasts:

Malena: It didn't work for my sister-in-law either. She caught it on her own. She

actually had to have an ultrasound.

Sara: Because the mammogram didn't detect it. They say that hers…her breast is

so dense they didn't see it…the mammogram couldn't pick anything up.

Jen: How does that make you guys feel that the mammogram doesn't…?

Sara: Insecure. That you can go every year, but you don't even know.

Ximena: Years ago, a lot of people depended on mammograms. You know, like,

you need to get your mammogram, it's important. Now, recently, you hear stories

like, oh, she had a mammogram, but it didn't detect it…

Self-efficacy. Based on these varied feelings of control, many women relied on their instincts to emotionally manage their cervical cancer attitudes and behaviors. The majority of women said that they have the Pap tests performed every year, and after that, they are not sure how else to prevent it. Penelope, for example, said that she doesn't know of anything else to do to prevent cervical cancer, so "I'm getting my annual, my job is done." Regardless, however, of their methods, most women said they are doing their best to manage their risk according to the information provided them. Gabriela explained that she wants to know her risks in order to feel comfortable that she is doing her best:

> I like to know what I am at risk for and, I guess, it's a way that I address those risks and I'm aware of those risks, and I know that I'm doing the best in my power and I feel comfortable that I am doing the best in my power…Because if it's completely out of my control – I wear a seatbelt when I drive, but if a drunk driver hits me and I'm doing everything in my power to drive well and protect myself, but there are some things that out of my control. At least I feel comfortable with what I'm doing.

RQ3: What type of public(s) do women of different racial and ethnic backgrounds represent regarding their communication behavior toward cervical cancer campaigns?

The women fall primarily into two categories of publics: (1) the older women represented an aware public because they were aware of the problem of cervical cancer and felt involved in the communication surrounding the risk; and (2) younger women represented a latent public because they felt connected to a larger problem they considered to encompass cervical cancer but they had low problem recognition concerning cervical cancer specifically.

The older women represented an aware public because they had (a) low constraint recognition, (b) moderate involvement, and (c) problem recognition. Even though the older women grouped women's issues together as did the younger women representing the latent public, the older women still expressed more problem recognition because they seemed to have more knowledge about it and they did not express a significant lack of understanding or knowledge about cervical cancer as did many of the younger women. First, the women did not express any concerns they have in particular about having their Pap test conducted annually. Secondly, in terms of problem recognition, Gabriela, a Hispanic woman in her early 30s, explained what cervical cancer meant to her: "I think about sex. I think about HPV. I think about lack of services to health care…HPV is a virus. When you have the virus, you have more chance to have your cervical cells develop into cancerous cells." Regarding involvement, in the Hispanic focus group, Pilar said even after her hysterectomy, she still has her cervix checked because she is concerned about cervical cancer:

Pilar: 35 years ago my uterus was removed. And every time I go to the doctor…

Malena: You have him check.

Pilar: Yeah.

Nadia: She just wants the doctor to touch her!

Pilar: Because I'm a widow, for 20 years! But now I have this woman doctor. Women can get the cancer in the cervix, in any part, anywhere. That's why it's good to…

Patricia: I go every year, and they do the check-ups, and OK.

The younger women represented a latent public because they had (a) moderate constraint recognition, (b) indirect involvement, and (c) low problem recognition. Regarding constraints, some women pointed to barriers such as lack of money or insurance and embarrassment over the lack of privacy. Their involvement was indirect because they were concerned about cervical cancer simply because it was part of their reproductive system, and they were primarily connected to reproductive issues because they did not want to hurt their ability to have children. Veronica, for example, remarked that not having children is a reason that cervical cancer is a concern for her: "That's a big women's health concern for me, is not being able to have kids. But otherwise, I don't need [the cervix] if it doesn't do anything, and I hope I don't get cancer because cancer can spread everywhere else." Finally, this public's problem recognition was low because some women admitted to not knowing anything about it, and other women did not have knowledge about what the risks, causes, effects, prevention, and detection methods are of cervical cancer. For example, prior to participating in these focus groups and interviews, several women did not know that the Pap tests they had been having performed on them for years was the detection method for cervical cancer. Additionally, several women – particularly those in the White focus group – were surprised that HPV was a cause of cervical cancer, and some women did not know what HPV was in particular or how it was formed. For example, while looking at the brochures, one woman asked questions to clarify her previous understanding of HPV:

Olivia: I thought HPV is like the technical name for herpes. That's wrong?

Veronica: They're different.

Lola: I just think of genital warts when I think of HPV.

Jen: Yeah, and some of them turn into genital warts also.

Olivia: Turn into? So that's not the same thing?

Lola: It's the same virus.

Jen: I know there are different strains, just like with herpes.

Additional Findings: How Women Viewed Themselves and Other Audiences Through

Communication

In analyzing the data, additional themes emerged that did not necessarily answer

the specific RQs set out for the study. In particular, the participants discussed why and

how they saw themselves in the communication about cervical cancer. They also talked

about what types of audiences they felt most appropriate for the cancer messages.

Self-Image in the Communication

As discussed earlier, many of the women did not feel particularly involved with

the messages they received from the brochures or from any previous communication they

had received about cervical cancer. Most of the women expressed that although some of

the information in the brochures was helpful to them for education about cervical cancer,

many did not see themselves in the images or feel like the messages were specifically

addressing them. The primary reasons women cited for feel disengaged from the

messages include discrepancies in perceptions of age; discrepancies in self-image

regarding race or ethnicity; and an overall lack of various cultural meaning making

symbols.

Age. Most young women said they believe older women were affected by cervical

cancer. The main reason the women perceived older age to be the differentiating factor

among those affected and unaffected by cervical cancer is because (a) younger women

had seen very little cervical cancer messages prior to the interviews, and (b) they believed the brochures portrayed women older to them. To this first point, Carolina, a Hispanic woman in her late teens, was not going to get a Pap smear because she did not feel her age group was targeted by the communication materials:

> Yes, well it's not – like I don't think – I think it's because I'm not aware of it. I'm not going to sit here and be like I could have this because I don't know anything about it, so like nothing in this brochure really targets anything to me that says I should really drop everything now and go get a Pap smear. Nothing in here says like you should get it because you might have it. For me, like in my mind I'm young. There is no way I can have this. There is no way I should get it.

Regarding the images in the brochures, Heather, a White woman in her late teens, said there were no young women in the pictures, only "business women." Likewise, Lisa, a White woman in her late 20s, said when she thinks about cervical cancer, she thinks about "older women that get cysts in their ovaries," particularly since "when you get older your tissue gets more not uniform." Lastly, Angela and Liz, both African American women in their mid- and late-20s, both explained that the cervical cancer materials did not speak to their communication preferences, which they both attributed to the spawn of the "MTV generation." Liz described how cervical cancer did not fit into that worldview:

> Weirdly enough, I think my first television health experience was on MTV. And they target things that are for the large population enough to understand, so I don't think currently anything about cervical cancer is targeted towards me or for my age. I think it's targeted more for women in their thirties and stuff.

Race and ethnicity. The large majority of the women interviewed did not feel that there were any differences based on various races or ethnicities in how women make meaning of cervical cancer. For example, the women from the Hispanic focus group did not perceive that race or ethnicity made a difference in how women perceived cervical cancer because they felt that "everyone gets hit the same." The only difference the women felt may exist is among women who do not have the money or insurance to pay for exams.

There were a handful of women who felt there were discrepancies, however. Amee imaged that the typical woman with cervical cancer would be "maybe early 40s, probably Caucasian just because I don't think many people in my race that I have heard of having cervical cancer." In the same vein, although Angela, an African American woman, did not necessarily think women of different races experience or perceive cervical cancer differently, she did explain what she looks for in health communication materials:

> What do the graphics represent? Do the graphics look like White people?…do the graphics look like people of color, even in the silhouette, do they look like people of color?…What groups are the colors associated with? I know about the National Medical Association. I know about the Black Nursing Association, I know about all these other minority groups that are out there with my community…Are they listed in this literature? I know then that they have some credibility…I look for a diversity of people…so when they use just White and black, I'm like, we're more than just a White-and-black society.

Lifestyles. Women felt there were other pieces missing from the cervical cancer communication they had received that represents their meaning making. Some of the young White women felt that the brochures were addressed to women who already had cervical cancer rather than women – like them– who did not have cervical cancer but needed more information about how to prevent cervical cancer. Where the women felt the brochures addressed needs for information about treating cervical cancer, the young women wanted information about how women in their positions – looking have children in the near future – could avoid cervical cancer in order to avoid not being able to have children.

In addition to not relating to pictures of White women, Gabriela, a Puerto Rican woman in her early 30s and a doctoral student in the health field, said she also does not relate to many pictures of Hispanic women because they look like "immigrants, which doesn't pertain to me." In particular, Gabriela said that messages that portray women of her age and her lifestyle – which she describes as a "working professional" – are more important to her than images portraying Hispanic women. In fact, she said an abstraction, or "an abstract image of a woman would do more for me than that depiction."

Finally, Amee, an Indian American college student, did not care about reading information about a specific health topic like cervical cancer or the Pap smear, but rather, she wanted information that related to her health as woman in the near future:

> Well, looking at the covers, all the ones that say healthy women tomorrow or
> what all women need to know, those I feel like I would read. But everything
> else, I just was like HPV and your Pap smear, I just feel like okay, I don't care.

I don't need that right now. You know but things that actually are more

general, instead of – like these, those would probably address more.

Amee explained that communication materials that only say "cervical cancer" or "Pap

smear" on the front cover do not indicate to her that there is something inside that she

needs to read. However, messages about "healthy women tomorrow" and "what all

women need to know" tell her that there is something inside that relates to her

specifically as a woman.

Chapter 5 – Discussion and Conclusion

This study used qualitative methods to explore how women of different racial and ethnic backgrounds made meaning of cervical cancer communication. Twenty-four Hispanic, African American, Indian American, and White women of various ages were interviewed in groups or individually to probe their perceptions of and behaviors regarding cervical cancer prevention and information seeking. A public relations theory – the situational theory of publics – was used as a framework for inquiry to understanding their meaning making of symbols, concepts, languages, rituals, and relationships as well as a guide for segmenting the women according to their information seeking behavior in the particular context of cervical cancer risk. Results reveal that women have not received messages about cervical cancer, and the majority of women do not actively seek cervical cancer information. Furthermore, the large majority of the women do receive regular Pap tests and, therefore, many women do not feel affected by the threat of cervical cancer. The women fall primarily into two categories of publics: (1) the older women represent an aware public because they are aware of the problem of cervical cancer and feel involved in the communication surrounding the risk; and (2) younger women represent a latent public because they feel connected to a larger problem they consider to encompass cervical cancer but they have low problem recognition concerning cervical cancer specifically.

The study adopted a cultural approach to understanding women's meaning making of cervical cancer communication according to their various cultural symbols, language elements, concepts, and consumption of media representations. Women made meaning through concepts such as the *lack of communication and promotion; grouping of*

women's issues together and their involvement as women; loss; control; privacy; and *their self-images in the communication*. Furthermore, some differences were found in how women perceive cervical cancer communication. Although there were slight differences for how women of different races and ethnicities preferred communication about health risks, the differences among how women made meaning about cervical cancer were primarily based on age. Younger women felt more involved with cervical cancer in terms of the threat it presented to them of disrupting their abilities to have children in the future. For the older women, this was not as much of a concern, but rather, they made meaning of cervical cancer by way of loss of sexuality and a change in womanhood and in their relationships with their husbands. Women provided a number of suggestions for messages, concepts, images, and placement and type of media they believed would be effective in communicating with women like them and gaining compliance regarding cervical cancer prevention behaviors.

Elaborating the Situational Theory of Publics

The situational theory was useful in understanding that the participants in this study can be divided into different publics because they make meaning about their involvement differently and they understand the problem of cervical cancer differently. This study found that although all women were aware that cervical cancer was a problem to an extent and most women did not present significant constraints to having a Pap smear regularly performed, the women varied in terms of their level of involvement. The women varied primarily according to their age: older women were aware of the problem and felt personally involved in the risk of cervical cancer, whereas younger women were aware of the problem but detached from their involvement in their personal risks.

Therefore, the women in this study represented two publics: those who make up an aware public because they have problem recognition of cervical cancer as well as involvement and low constraints (the older women), and those who comprise a latent public because they have high involvement and low constraints but no problem recognition about cervical cancer (the younger women).

However, nuances exist in both the level of involvement– as just discussed – and problem recognition. The data raised several questions that have not been previously addressed in exploring the situational theory of publics: To what extent does a public recognize an issue to have a consequence (problem recognition) when the public does not accurately and thoroughly understand an issue? To what extent does a public recognize an issue to have a consequence when the public perceives incomplete consequences of the problem on them (level of involvement)? When a public complies with the suggested behaviors but complies for motives other than those advocated by an organization regarding a threatening issue, how does that fit into the situational theory of publics?

As these questions suggest, the problem recognition and involvement levels of these women did not fit neatly into the traditional definitions of the variables. Therefore, during data analysis, I struggled with understanding what type of publics these women composed. However, this ambiguity reveals opportunities for expanding the situational theory by way of innovating the definition of the level of involvement (to be discussed next), particularly for publics of women regarding their meaning making of health. In other words, the current conceptualization of involvement may be too simplistic when researching women regarding their health because involvement may be dependent on culture and the particular health topic.

Level of involvement. Level of involvement is defined by Grunig and Hunt (1984) as "the extent to which [people] connect themselves with the situation" (p. 152). The participants of this study connected themselves to an issue, but the older women and younger women were divided along this variable, which is why they constitute different publics. The older women (aware public) felt connected to the issue of cervical cancer specifically, and they obtained their annual Pap tests in order to detect cervical cancer. The younger women (latent public) felt connected to a larger issue of preserving their reproductive health in order to be able to have children, and they obtained their Pap tests annually in order to do so. These women reported that they obtained their Pap tests as an obligation to someone's advice, and they performed the test routinely. Some performed the Pap test as part of a routine to obtain oral contraceptive pills. They also reported that they grouped together their reproductive body parts and health issues, and they complied with suggestions given to them that would prevent problems for reproduction, such as STD prevention, cervical cancer, ovarian cancer, breast cancer, and endometriosis.

According to the traditional definition of involvement, these younger women do not necessarily feel connected to cervical cancer, but rather, they feel connected to the larger issue of threats to their reproductive health. This is evidenced in the women's perceptions that they felt unaffected by the communication sent to them about cervical cancer, partly because they did not feel the messages spoke to them and partly because they did not feel they needed persuasive messages because they believed they were already complying with the suggestions to get their annual Pap smears. For other women – particularly the older women – the loss of sexuality and womanhood as well as not being able to satisfy a sexual or relationship partner were the major fears that emerged in

the discussion about cervical cancer. Therefore, these women may not have necessarily recognized cervical cancer as a problem that needed to be solved, and they did not seek information about cervical cancer or fulfill the suggested behaviors in order to prevent developing cervical cancer. Instead, they were involved with and motivated by a completely different problem – to stave off any threat to their abilities to have children – which they believed encompasses the cervical cancer threat once it was addressed in the interviews.

Therefore, the women in this study represent the need for a more nuanced and sensitive conceptualization of involvement. In particular, women in this study demonstrated that their cultural commonality – being a woman – binds them in how they group sexual and reproductive health issues together. Furthermore, they address these health issues from a standpoint of preservation in order not to lose some ability, whether it be to have children, to feel sexual, to feel like a woman, or to be able to satisfy some sexual or romantic partner or themselves. Therefore, this study suggests that involvement for women and health may be the *extent to which women connect themselves to the cultural issues of being a woman and preserving qualities they perceive as representative of that cultural identity*.

Problem recognition. The women in this study divided again by problem recognition. The older women had more knowledge about cervical cancer than did younger women. Some of the younger women came to the interviews admitting that they did not know anything about cervical cancer, whereas other women – and mostly women of older ages – knew about cervical cancer and had stopped to think about it prior to the interviews. All women surmised that cervical cancer was a problem when I asked them

about it, because it contained the word "cancer" in the name. Some women provided me with wrong information about the disease, and several women admitted that prior to the interviews, they did not know that they were being tested for cervical cancer when they had Pap tests.

These findings suggest that publics can still comply with health recommendations even if they do not recognize the particular health problem, but feel involved with an overarching threat instead of with a particular health threat. Even though they comply with the behavioral suggestion of having Pap tests performed, this may not be enough to guard against cervical cancer without actual, complete knowledge of the causes, prevention behaviors, and detection methods. In the present case, this becomes problematic when women stop taking contraceptives: if women do not understand the complexity of the cervical cancer threat and the prevention – having protected sex and a number of other factors – and the detection methods – yearly Pap tests and appropriate follow-up compliance to abnormal tests – women may not be aware of their risk and may leave themselves susceptible to infection. For example, Veronica exemplified this risk in her recounting of a college memory where a friend provided her with many packs of inexpensive oral contraceptives from the health center, so she did not have to go to the doctor for her Pap test for "a long time." Therefore, even though this situation of disguised active information seeking and compliance with suggested behaviors seems tolerable and safe for the moment, realistically, the threat of women either being misinformed or uneducated about a health threat like this presents a severe public health and public relations problem and a potential constraint in the future.

This study, therefore, highlights the importance of the knowledge element within the problem recognition piece of the situational theory. Whether *knowledge* could operate alone or as a moderating influence on problem recognition, the data suggest that *the extent of the women's knowledge is related to the extent to which they perceive a health threat as a problem.* This, in turn, may determine the quality and the duration of the compliance to the suggestion behaviors and information seeking about the health threat. This study shows that without proper understanding of a health threat, publics may be as susceptible to the threat as if they did not comply – even indirectly – with the health messages.

Constraint recognition. Grunig and Hunt (1984) defined constraint recognition as "the extent to which people perceive that there are constraints – or obstacles – in a situation that limit their freedom to plan their own behavior" (p. 151). The women's perceived barriers and subsequent behaviors toward cervical cancer reflected this current conceptualization. For example, a few women discussed the constraint of lack of money or lack of insurance as a reason for why they would not be able to comply with the messages sent to them. In particular, Fallulah said that she had not had her annual Pap test that year because she did not have insurance and did want to spend the money. Also, privacy and discomfort emerged as constraints for seeking cervical cancer information in certain contexts.

However, I should note that when I asked the women how they would not be able to comply with the suggested behaviors, almost all of them said by not getting their Pap smears. But, the women said, they felt they complied with the messages appropriately because they obtained their regular Pap tests. Therefore, although many of the women

behaved by obtaining Pap tests, almost none of the women actively sought information about cervical cancer or formed together to do anything about the disease. Hence, this study shows that although women have constraints to seeking information about Pap smears – due to privacy issues and lack of insurance – they still perform the recommended behavior of having their Pap tests because their levels of involvement were significant enough to overcome the constraints.

This finding further validates the major differentiation between the two publics of women because they are obtaining Pap tests based on their knowledge. Specifically, the older women are obtaining their Pap tests and overcoming any barriers because they know that cervical cancer is important because it means loss to them. Differently, the younger women are overcoming barriers and obtaining their Pap tests routinely because they believe they have been told to by figures of authority or credibility, or they have to have a Pap test in order to refill their oral contraceptive prescriptions. The latter group is not obtaining the Pap test because they know cervical health is important to maintain, but rather, they believe their reproductive health – which includes theircervix – is important in order to have babies. Therefore, both groups experience constraints and overcome them, although lack of knowledge and understanding about the topic could develop into a constraint in the future.

Developing Theory of Women's Health Communication

This study supports Aldoory's (2001) finding that women are more concerned with getting their daily needs met and providing for their families before they are concerned about seeking information regarding their own health. The women in this study had similarly grounded concerns in that they had daily life needs for which they

pursued daily information seeking as well as needed medical attention. For example, many of the younger women expressed that they are more concerned with getting their oral contraceptive prescriptions refilled as well as making sure they have their overall reproductive health stable rather than seeking information for any particular health threat. Additionally, the older women said they are more concerned with other health threats – like breast cancer and heart disease – and, therefore, do not seek information specifically about cervical cancer. All women are more concerned on a daily basis with their relationships and aspects of their womanhood.

This study's findings also emphasize the significant need for women to understand health threats particular to them better but also women need to be able to get information from their doctors about such health threats in more effective ways. The interviews were laden with comments about the insecurities and discomfort women felt with their doctors, which may significantly contribute to the lack of information these women generally have about their reproductive health and the threats to that health. In fact, a few women even accused their doctors for their not knowing the linkage between cervical cancer and Pap tests because they believed their doctors never told them during their Paps that they were being tested for cervical cancer. Overall, these two communication quandaries point to the importance of teaching health literacy to women so that they have more confidence in getting their questions answered from their doctors by using methods to making their relationship with their health practitioners more effective, productive, and beneficial.

This study also answered Pompper's (2005) call to action for conducting public relations research according to Critical Race Theory (CRT). By (a) asking research

questions that are grounded in scholarly and human curiosity about difference according to race, ethnicity, and culture, (b) stating my epistemology as one that acknowledges my standpoint but remains anthropologically exploratory of those different from me, and (c) using qualitative methodology in order to highlight differences rather than subdue variation and graduate it into a patterned, predictive norm, this study uses the CRT for Public Relations Theory as a guiding principle and supports its nomination. Furthermore, this study elaborates on the CRT for Public Relations Theory by emphasizing culture as a publics-driven creation, and this study finds that public relations research should not only approach culture as a racial or ethnic concept but as a gender, age, orientation, class, and lifestyle perspective to be explored as well.

Furthermore, the women in this study demonstrated that they group their reproductive body parts, processes, and health threats together. This study provides a look at how publics composed exclusively of women perceive a specific health threat and how they seek information and comply with the suggested behaviors, based on the messages and communication materials provided them. Most women said that they had not seen health messages about cervical cancer before, but that they comply with obtaining their Pap smears annually because they are concerned about their reproductive and woman's health in general due to fear of losing their reproductive ability and womanhood. *Therefore, (a) messages about loss of the ability to be a parent, of sexuality, and of being in a sexual relationship may resonate more with women than will piecemeal messages about disparate women's health threats, and (b) understanding that women group these health issues together may mean that women's health as a practice, science, and communication type should be reconsidered and potentially reframed.*

Cultural Theory

This study discovered that women make meaning of their culture partly through gender: most women said they felt like cervical cancer meant something to them because they are women and they have a cervix. Furthermore, the women's meaning making of loss exemplified their cultural importance on gender because many of them spoke of their fears of losing something about them that was particular to their gender (i.e., motherhood, womanhood, female body parts).

In examining the actual media (e.g., either via the brochures provided or any messages they recalled), women exhibited meaning making of gendered symbols. For example, there was significant criticism to one of the brochures that pictured a drawing of a male physician examining a woman, illustrating the Pap test. In reaction to this, many women discussed their discomfort with having a male gynecologist. The women also made meaning of the pictures of the women and felt connected to the images according to the age, race, and perceived lifestyle of the women. The women's words illustrated that women prefer to see images of women that they perceive to look like them and have a lifestyle similar to theirs.

This study used the circuit of culture regarding a particular physical health application. Other cultural studies searching for meaning making among women investigated communication and media phenomena regarding general health conceptions (Aldoory, 2001; Martin, 2001), feminist and women's political topics (Acosta-Alzuru, 2003; Press & Cole, 1999), and women's consumption of various texts (Bobo, 1995; Duncan & Robinson, 2004; Grodin, 1991; Radway, 1984). In this thesis, the data are grounded in specific recalled messages, experiences, and memories that help readers

better situate these women's meaning making experiences. Women's health researchers and communicators can use the findings as a baseline measure for studying communication consumption and information seeking from a cultural perspective so that communication relationships can be established and fortified with women publics using more adroit cultural symbols, concepts, and codes.

The 'other'. Women with STDs were othered by a significant portion of these women. When STDs were discussed, many women seemed to make meaning through very distinctive, standards-based values in which they perceived themselves to be on one side of the distinction, and they situated women with STDs on the other side. Several women used heavy, negatively-valenced language – such as the words ugly and dirty – when I asked about their perceptions of STDs or when a discussion about avoiding developing cervical cancer via HPV infection. Women also discussed their perceptions of the death of a happy livelihood and quality social relationships when a woman was infected with an STD through phrases like, "you're Xed, you're done now" and "you're plagued now." Other women said that a woman's sexual life would end because other people would not want to be intimate with them any longer for fear of being infected. In fact, a couple of women in a focus group discussed their perceptions that women with an STD cannot accomplish life events.

Finally, I entered into this study curious about how women from different racial and ethnic backgrounds make meaning of cervical cancer communication because I supposed they may make meaning differently. Although the data did not explicitly indicate that women made meaning in significantly different ways, it should be noted that there may be reasons why this phenomenon did not overtly emerge. First, I may not have

developed the rapport with some Hispanic, African American, or Indian American women that I may have with White women since I am a White woman. Thus, some non-White women may not have felt comfortable talking to me about racial differences. Secondly, although I did ask women a question from the interview protocol than explored the extent to which they perceived that there could be differences among different races regarding how women perceive cervical cancer information (How do you feel about cancer as a(n) African American/Hispanic/Caucasian woman that may be different or unique from other groups affected by cancer?), women may have found the question was worded confusingly or awkwardly, and thus, the question may not have elicited the information I was hoping to gain. Finally, the limitation that I was not able to gather a focus group of African American women as I did with Hispanic and White women may have detracted from the opportunities from which I could have obtained this type of information.

Research on Cervical Cancer Interventions

This study extends the cervical cancer communication literature by expanding what communication research knows about the barriers women face and women's motivating factors regarding cervical cancer. Whereas the majority of previous studies used quantitative surveys or quasi-experimental interventions to learn about and promote cervical cancer screening, this study delved deeper into the meaning making of cervical cancer communication as a cultural concept for women from different racial and ethnic backgrounds. For example, extant literature had not uncovered or emphasized women's fear of loss of womanhood, parenthood, and sexuality, women's perceived constraint of embarrassment and need for privacy, and women's evaluation of cervical cancer within

their criterion of personal control against diseases. Additionally, no study was found that had specifically examined women's various levels of information seeking based on their recognition of the problems, constraints, and personal involvement felt regarding cervical cancer.

Specifically, this study confirmed Fernandez-Esquer et al.'s (2003) findings that women should be targeted according to their ages based on their level of involvement in family planning and other reproductive health issues. However, this study found that older women, rather than women below 40, as Fernandez-Esquer et al. found, had more knowledge of cervical cancer and felt specifically connected to cervical cancer, whereas this study found that younger women felt more connected to their concerns of their grouped reproductive parts and concomitant reproductive issues. Also, this study confirmed several previous studies' suggestions of constraints, such as lack of money to pay for Pap cost (Harmon et al., 1996; Suarez et al., 1994), fewer previous medical conditions (Wu et al., 2001), and poor communication with physicians (Hunt et al., 2002). Furthermore, in Wu et al.'s study of why Mexican-American women are consistently never screened for cervical cancer, they attributed the discrepancy to the possibility that women have a higher awareness of the threat of breast cancer and needed mammogram screening because breast cancer promotion largely overshadows cervical cancer promotion. My study confirmed this also because several women said they know little about cervical cancer because they have not seen messages about it, and therefore, they do not feel cervical cancer is a severe threat to them compared to the threat of breast cancer. Practically and theoretically, this study contributes significantly to the cervical cancer literature concerned primarily with communication to and by women publics.

Practical Implications

Cervical cancer communication. This study has provided a number of suggested innovations for how organizations advocating cervical cancer prevention, detection, and treatment behaviors can communicate better with women. First, the study shows that women should be segmented according to age and messages should be tailored to address the current involvement women of different ages feel toward cervical cancer. Furthermore, communicators should understand that women often group their reproductive body parts and health issues together, and messages should encompass cervical cancer along with other health issues together as the overarching reproductive health problem to recognize. To this point, communicators should consider using messages that emphasize poor cervical cancer prevention and detection can mean losing some womanly, sexual, or reproductive abilities. Finally, communicators should consider that women are sensitive to racial, ethnic, age, and lifestyle portrayals, and thus, messages to various groups should be customized accordingly.

Women's health. This study presents the suggestion that health communication should shift dramatically in its approach to communicating with publics about health issues through topic-centric messages. Rather than displaying brochures, posters, magazine and television public service announcements, and other mass mediated techniques that sport titles of diseases or medical procedures, the women in this study advocated for thematic messages. For example, Amee felt the brochures with messages about "health women tomorrow" spoke to her more personally than did messages about "HPV and your pap smear" because she believed the former signals to her more clearly that there was something inside the brochure important for her to read. Likewise, the

focus group of White women in their early 20s emphasized that one of their greatest fears was the inability to have children, and that any messages addressing that fear would grab their attention and compliance more so than the brochures they reviewed. Both Amee and the focus group said that the cervical cancer materials they reviewed seemed to be targeted to women who were already looking for information about cervical cancer or who had cervical cancer. Health communicators trying to build relationships with women publics around health issues should research the issues women find most important and providing health behavioral suggestions and information around cultural themes.

Limitations of Study

There were some limitations to the research, particularly regarding recruitment of participants. First, due to time and resource limitations, I was unable to interview women from more races and ethnicities. Interviewing women from a broader range of backgrounds would increase the validity of the findings regarding how women from different groups make meaning of cervical cancer. I was also unable to recruit more women in their 40s, 50s, 60s, and 70s. Since women in their older years are also a high-risk group for cervical cancer, it would have been helpful to interview more women from these age groups. Finally, in order to have a more complete perspective of women's meaning making of cervical cancer communication, it would have been better to talk with women from low socioeconomic backgrounds in order to determine their knowledge levels and their constraints to seeking information. This study consisted mainly of women with access to education and funds for medical attention, which may have been a reason why these women were able to comply easily with getting annual Pap tests.

Another limitation may have been the manner in which the women viewed the campaign materials. The interview sessions began by asking the women about their perceptions of health, their major health concerns, their meaning making of cervical cancer, and the extent to which they have seen or heard messages about cervical cancer. Halfway through the sessions, I provided the women with brochures about cervical cancer and Pap tests. I did not include a systematic way of showing the women the brochures, nor did I require the women to look at all of them or only a few; rather, I asked the women to peruse them any way they wished and to tell me their perceptions about any one(s) they preferred. This lack of consistency might have reduced the validity of the findings because all the women did not necessarily examine and critique the same brochures; however, as a study founded in the feminist standpoint epistemology, asking the participants to explore the brochures and discuss their perceptions as they pleased allowed the women to make meaning as they would have in a more natural setting. The brochures with the most culturally relevant features may have been the ones about which the women decided to comment.

Future Research

Public relations research. A long-term ethnography on a woman – or a close group of women – could be useful in learning how involvement changes over the years as a woman moves from her late teen years into her late 20s or even early 30s. A researcher could note particularly her information sources, her communication with her gynecologists and other doctors, her problem recognition of cervical cancer, and her information seeking about the topic. A meta-analysis of studies examining the depth of information seeking and types of problem recognition would be helpful in identifying the

extent to which the new conceptualizations apply, although this may be difficult considering the few number of studies applying the situational theory to women publics specifically. Finally, a survey of women or another study of women's information seeking behavior regarding another health application – such as breast cancer, ovarian cancer, or endometriosis – would better indicate the extent to which the new conceptualizations persist across groups of women and across health topics.

Furthermore, as previously asserted, since the study was conducted in the tradition of qualitative inquiry, the results may not be replicable in future studies. However, some themes found in this study may emerge in other studies, which may indicate that the themes are persistent among certain cultural groups. The next step, then, would be to empirically evaluate the extent to which the themes can be generalized. Campaign designers can create preliminary messages using the persistent themes, then pilot test them with women representative of the cultural groups to which the messages were designed. The extent to which the women respond positively to the messages may correspond with the extent to which the messages may be generalizable to the wider population of the culture. If the messages do not receive positive responses, the themes then should be reevaluated qualitatively in order to determine more accuracy about important themes to the various cultures of women.

Women's health research. As indicated by many of the participants, their relationships with their doctors seemed to strain their understandings of cervical cancer as well as their comfort about their reproductive health in general. Health communication literature stresses the need for more education about health literacy, which advocates that consumers learn how to better communicate with health practitioners in order to have

their questions adequately answered and their concerns properly addressed. Therefore, researchers should examine how women can more easily talk to their doctors, particularly about sensitive issues such as cervical cancer, STDs, and sexual activity. Studies should also investigate what factors deter women from asking doctors questions when they do not understand something about their bodies as well as the factors that deter women for asking for clarification when they do not understand a piece of information the doctors give them. Factors should also be examined to understand why doctors may not offer vital information during exams, such as the link between Pap tests and cervical cancer detection. Since problem recognition differentiated a segment of women from another, reducing this constraint – the ability to communicate effectively with doctors – could improve problem recognition of cervical cancer in some women and help them become more educated and self-aware women's health consumers.

 Cultural studies. Now that the consumption element of the circuit and the decoding part of the process have been examined, the other pieces should be explored. Encoding should be investigated, which involves how the producers of communication determine which cultural symbols are best representatives of the concepts being communicated, and the process by which these codes are constructed and disseminated (Hall, 1993). In the circuit of culture, this encoding process combines with the production element of the circuit. Researchers conducting future studies should interview the producers, designers, and communicators within a cervical cancer organization or department to determine how they determine the publics to which they will communicate, how they research their publics, and how they determine which messages, images, and media and interpersonal communicators to use to accomplish the goals of their public

health campaign. Investigating the other three elements of the circuit of culture –
identification, representation, regulation – would provide a holistic perspective of how
the public health threat to women of cervical cancer is culturally situated across a number
of age and racial/ethnic segments of women.

Participants. To further triangulate the perspectives provided in the study,
additional segments of women should be interviewed. More older women should be
interviewed as well as more women who are in their late 30s to early 50s. Researchers
should also explore the reasons older women tend to have more involvement with
cervical cancer – could involvement be related to the numbers and types of life and
sickness experiences women garner as they grow older? Or could higher involvement be
a product of the reality of reaching menopause, and thus, a reproductive cancer is
perceived as a more authentic, possible threat to women anticipating those events?
Women from other racial and ethnic groups should be interviewed. Furthermore, women
in lower socioeconomic positions should be interviewed in order to determine their
meaning making of cervical cancer along with their constraints, particularly since this
study found that the main constraint women perceived in getting regular Pap smears was
the lack of money or insurance.

Implications of Study

The purpose of this study was to understand how women from different racial and
ethnic backgrounds made meaning of cervical cancer communication. Using feminist
standpoint theory as my guiding epistemology, I conducted a qualitative, cultural study to
learn about how African American, Hispanic, Indian American, and White women make
meaning of cancer communication. I did this by using the situational theory of publics

(Grunig & Hunt, 1984) as my guiding framework to understand if/how women seek information about cancer, and if they do, why/not they comply with the messages. In this exploratory cultural study, the theory's independent variables of problem recognition, constraint recognition, and level of involvement helped me recognize that the women comprised two different publics which were different according to their amount of acknowledgement of cervical cancer as a problem and the extent to which they felt personally connected to cervical cancer. The findings contribute to the field of public relations by extending the situational theory by customizing the level of involvement variable to fit women publics better when they receive messages about a health application, particularly one that women perceive to pertain to their womanhood and parenthood.

The findings also contribute to a theory of women's health communication by adding a layer to a developing theory (Aldoory, 2001) about how women's perceptions of their culture interact with their information seeking behaviors about women's health issues. Age emerged as a primary cultural differentiator among women because women perceived cervical cancer to affect them differently according to their perceived stages in their womanhood: the younger women were concerned about forthcoming motherhood, whereas the older women were concerned about loss of sexuality, losing their relationships with their husband, and having their cervixes removed. Racial, ethnic, and lifestyle factors also emerged as cultural meaning making differentiators as well. Thus, communicators should not only consider and be sensitive to these factors in developing women's health communication programs and messages, but communicators should intently, humbly, creatively, and dialogically try to understand how women use these

cultural indicators to situate cervical cancer communication in the women's personal

worlds.

Appendix: Interview Guide Used in Focus Groups and Individual Interviews

1. What does the word "health" mean to you?
      Probe: What is one of your major health concerns today?

2. When I mention cervical cancer, what do you think about?

3. What do you think cervical cancer means to your family and friends?

4. Where would you turn for information about cervical cancer? What places in your community can you turn to when you are concerned about cervical cancer?
      Probe: Which media do you use for information?
      Probe: What resources do you have to discuss concerns like cervical cancer?

5. What are some situations in which you are more likely to seek health advice from others? (Mizell Price, 2002, pp. 358-359)

6. To what extent have you seen or heard any messages regarding cervical cancer?
      Probe: How often do you see or hear messages about cervical cancer?
      Probe: What did they say/communicate to you?
      Probe: Please describe the messages.
      Probe: What do these messages address?

Please look over the materials from the cancer campaign.

7. How well do you feel like the messages in these materials address your needs for information?

8. How do these messages make you feel?

9. To what extent do you think these messages are targeted to you?
      Probe: If they are not, whom do you believe the messages target?

10. How well do you feel you comply with the messages sent to you regarding cancer?
      Probe: How does your level of compliance make you feel?

11. How would you change the messages if you could make them "talk" to you better?

12. If you could change the way that women receive information about cervical cancer, how would you change it?

13. How do you feel about cervical cancer as a(n) African American/Hispanic/Caucasian woman (with children, if applicable) that may be different or unique from other groups affected by cervical cancer?

14. To what extent do you feel capable of avoiding or maintaining cervical cancer, based on the information you have seen here about it?

15. What are reasons why you would not be able to manage cervical cancer the way you would like to?

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