

## Chapter 8

# The Communication Theory of Identity as a Framework for Health Message Design

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### INTRODUCTION

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Individuals' identities influence the formation of their beliefs, attitudes, and behaviors. As a result, many scholars have studied identity to determine its effects on individuals' health choices, values, and actions, under the assumption that identity and health are inextricably entwined (e.g., Haslam, Jetten, Postmes, & Haslam, 2009). "Healthy," itself, often becomes an identity, and messages about what it means to be a healthy person pervade health campaigns. As a result, it is essential to apply a comprehensive approach to identity to more fully understand its role in health.

Western identity theories argue that individuals behave in certain ways to remain consistent with their ingroup's norms (social identity theory; see Harwood & Giles, 2005; Tajfel & Turner, 1986) as well as the social roles, norms, and interpretations of self (as explicated in symbolic interactionism;

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see Cooley, 1902; Mead, 1934; Goffman, 1967; Schlenker, 1985). While these two approaches play a particularly dominant role in identity research in Western science, non-Western traditions consider identity through the lenses of paradox and polarity, holism, collectivism, as well as the interplay between and among these constructs (Hecht, Warren, Jung, & Krieger, 2004). While a thorough review of these perspectives is beyond the scope of this chapter, they informed the development of the communication theory of identity (CTI). This theory draws upon a layered perspective (Hecht, Jackson, & Ribeau, 2003; Hecht et al., 2004) to integrate these diverse perspectives. We briefly describe these contributions. For a more extensive discussion see Hecht et al., 2004.

From social identity theory, CTI draws on the notion that identity is based on social categorization and shared group memberships (e.g., Turner, 1991). Societal norms and practices are internalized in the form of social identities based on social categories (especially in/outgroup distinctions). CTI, however, sees influences beyond the group and the comparison process. Some of these emerge from identity theory.

Identity theory (Cooley, 1902; Goffman, 1967), based on symbolic interactionism, provides CTI with an explanation of the relationship between society and individuals. The theory postulates that identity is based on roles, other people's ascriptions, and social constructions and performances (Banton, 1965; Goffman, 1967). These are internalized and form role identities that are then constituted in relation to others and performed. While accepting many of these concepts, CTI breaks with this approach, seeing social behavior, itself, as an aspect of self—the enacted identity. That is, a person's sense of self is part of his or her social behavior and the sense of self emerges and is defined and redefined in social interaction. CTI also centers identity as relational and takes into consideration identity as a discursive process.

At first glance, these roots seem conflicting and inconsistent. CTI utilizes Eastern philosophy (e.g., Taoism and Confucianism; see Hecht et al., 2004) and postmodernism (Kellner, 1992) as vehicles for this integration. From Eastern thought, identity is seen as paradoxical, with polarities driving process but not necessarily dysfunction. From postmodernism comes the understanding that identities are layered and most identity theories are layer specific. Building on these traditions, the communication theory of identity expands the notion of identity to view it as layered (Faulkner & Hecht, 2007). From this theorizing emerged CTI's definition of identity as the multilayered ways that individuals and communities socially construct themselves.

We offer the CTI as an identity-based approach to health communication. This chapter explains CTI and provides examples of how identities are related to health behavior under the frame of CTI. Finally, we offer some guidelines

for using CTI to construct and deliver health messages to targeted individuals. Our goal is to explicate the intricacies of health and identity and provide a framework for theory, research, and practice. We start with an explanation of CTI and the relationship between CTI and health.

### WHAT IS THE COMMUNICATION THEORY OF IDENTITY?

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CTI was developed based on theory and empirical data suggesting that communication is an element rather than just a product of identity. Among an emerging group of theories seeking to view identity as more processual and layered, CTI presents a more comprehensive or synthetic view of identity integrating community, communication, social relationships, and self-concepts, while “locating” identity in all these layers.

CTI has 10 common axiomatic propositions (for more information on these propositions and extension to each of the frames, see Hecht et al., 2004).

The basic overarching propositions further define identity and are:

1. Identities have individual, social, and communal properties.
2. Identities are both enduring and changing.
3. Identities are affective, cognitive, behavioral, and spiritual.
4. Identities have both content and relationship levels of interpretation.
5. Identities involve both subjective and ascribed meaning.
6. Identities are codes that are expressed in conversations and define membership in communities.
7. Identities have semantic properties that are expressed in core symbols, meanings, and labels.
8. Identities prescribe modes of appropriate and effective communication.
9. Identities are a source of expectations and motivations.
10. Identities are emergent.

This “layered” perspective views one’s identity formation and management as an ongoing process of communication with the self and with others rather than as a simple product of communication or basis for producing communication (Hecht, 1993; Hecht, Jackson, & Ribeau, 2003). The theory posits that individuals internalize social interactions, relationships, and a sense of self into identities through communication. In turn, identity is expressed or enacted through communication. In other words, the relationship between communication and identity is reciprocal. From this perspective, communication helps build, sustain, and modify one’s identity.

In addition, CTI conceptualizes identity as a collective or group quality. As a form of social construction, there is a “shared” element to identity. Just as members in certain groups recognize or share a particular language, beliefs, norms, and culture, they also share common images of “selfhood” or identity that transcend individual group members and are reflected in cultural products and myths.

As a result, CTI suggests that there are four layers of identities—personal, enacted, relational, and communal layers—that interact with and are influenced by each other (e.g., Hecht, 1993; Hecht, Jackson, & Ribeau 2003). In other words, the four layers of identity do not exist separately. They always are interconnected with each other, a quality that is labeled “interpenetration.” However, for analytical purposes they often are defined and understood separately. The following subsections describe the basic premise underlying each of the four layers and the relationships among them (Hecht, 1993; Hecht, Jackson, & Ribeau, 2003).

### *Personal Layer and Health*

The personal layer refers to the individual as a locus or frame of identity. This layer may be thought of as being analogous to one’s self-concept, self-image, self-cognitions, feelings about the self or self-esteem, and/or a spiritual sense of being. The personal layer of identity provides an “understanding [of] how individuals define themselves in general as well as in particular situations” (Hecht, Collier, & Ribeau, 1993, pp. 166–167). Someone who says “I am smart” (or funny, or energetic) is articulating a personal identity. Many facets of personal identity are related to health. The most commonly studied personal identities in the health context are gender (e.g., Wade, 2008), ethnicity (e.g., Barger & Gallo, 2008), and health identity (e.g., Hagger & Orbell, 2003).

### *Enactment Layer and Health*

In this layer, identity is seen as being enacted in communication through messages. This layer conceptualizes identity as a performance, as something being expressed. Thus, in this layer communication is the locus of identity. When people communicate in a persuasive or articulate fashion, they may be enacting an identity. Some of these enactments have significant outcomes for health such as when people participate in breast cancer marathons, revealing to others that they are cancer survivors. Other cancer survivors enact their

identities by sharing their cancer narratives (Ford & Christmon, 2005). This realm of identity has been studied less than the personal and relational layers, thus leaving room for future health communication research.

### *Relational Layer and Health*

In this layer, relationships are the locus of identity. Here, identity is seen as a mutual product, jointly negotiated and mutually formed in relationships through communication. There are three aspects of the relational layer. First, an individual constitutes his or her identities in terms of other people through social interaction with others. The formation and ongoing modification of a person's identity is influenced by other people's views of that individual, especially ascriptions and categorizations. For instance, an individual may form a relational identity as a "good person" through being described this way by parents and friends. Second, an individual creates his or her identity by identifying through or in light of relationships with others, such as marital partners, coworkers, and friends (e.g., I am a husband, accountant, friend, etc.). Social roles are particularly important in shaping this aspect of identity. Third, a relationship itself can be a unit of identity. Thus, for example, a couple can establish an identity as a unit. Someone describing himself or herself as a boyfriend or a girlfriend of someone is articulating a relational identity.<sup>1</sup>

Health behaviors also are influenced by how people define their relational identity. This can be as simple as determining who makes health-related decisions or as complicated as healthy or unhealthy relationships. For example, through national panel survey data from 1986 and 1989, Umberson (1992) showed that wives were more likely to try to control family health than husbands. Many studies also indicated that adolescents who have smokers as friends or best friends are more likely to smoke (Alexander, Piazza, Mekos, & Valente, 2001; Urberg, Degirmencioglu, & Pilgrim, 1997).

The degree to which a person's identity is embedded in his or her relationships plays an important role for an individual's well-being. When people lose or switch their relational identities (e.g., divorce, death), they are more likely to engage in negative health-related behaviors such as drug use (Umberson, 1992). The ease with which individuals can change their relational identities also influences psychological symptoms. For example, more voluntary or transient identities (e.g., friend, churchgoer) reduce emotional distress, while more permanent identities (e.g., parent, son, daughter-in-law) reduce emotional distress only when the individual experienced low identity-related stress (Thoits, 1992).

### *Communal Layer and Health*

As noted above, the group also is conceptualized as a frame or location for identity. While group membership (e.g., gender, race) can be the basis for personal identity, the collectivity or community, itself, has identities. While such a view may seem alien to the individualistic world of Western social science, communal identities are manifest in numerous ways. Group members share common characteristics, histories, and collective memories that transcend individuals and result in commonly held identities. Sometimes these identities are manifested in stereotypes, but other times they are simply the cultural code for the group members' being—namely, how the individuals are socially constructed at the group level.

Saying that the TV show *The Office* provides a view of professional identities or *Friends* and *Seinfeld* articulate friendship identities or “Dilbert” is an engineering identity (perhaps even a geek or nerd identity) demonstrates the notion of the communal identity. Unfortunately, the negative stereotypes attached to ethnic or gender identities also are communal identities. As you can see, communal identities such as “Dilbert” can easily be seen as stereotypic when applied in a rigid fashion to group members.<sup>2</sup> Place identity, such as identifying with a rural area, is another example of communal identity's effect on health when it influences issues such as access or quality of care (Ching, 2001). Communal identities have other significant health effects, including their role in health disparities (Ndiaye, Krieger, Warren, Hecht, & Okuyemi, 2008). For example, the marginalization of rural residents through stereotyping them as unsophisticated (Krieger, Moreland, & Sabo, 2010) can influence their interactions with health care providers.

## **INTERPENETRATION OF LAYERS AND HEALTH (IDENTITY GAP)**

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Linguistic limitations led to the articulation of four layers, although they were never meant to be seen as separate. Many of the questions about CTI center around this “overlapness.” For example, one might ask, “Is race a personal or communal identity?” The answer is that it often is both. Individuals may personally identify as a member of a racial group (see, for example, work on African American identity in Hecht, Jackson, & Ribeau, 2003) while racial groups, themselves, may also have communal identities. These two layers make it possible to ask if someone is “X (substitute the name of your favorite group) enough.”

As a result, CTI argues that the four layers of identity are not conceptualized as separate from each other but rather as “interpenetrated.” Interpenetration

can be understood using the ocean and its tides as an analogy; individual tides can be identified on their own, but the ocean is still a whole that includes these “separate” tides. In the same way, the identity layers can be identified independently but together make up a whole. Thus, identity analyses are enriched if they consider the layers two at a time, three at a time, or all four at once.

There are a number of ways that interpenetration can be examined. Some of the work reflecting interpenetrations focuses on “identity conflict” (Baumeister, 1986; Lin, 2008). To date, CTI research has focused on the health implications of “gaps” between and among the layers. Jung and Hecht (2004, 2008; Jung, Hecht, & Wadsworth, 2007; Wadsworth, Hecht, & Jung, 2008) conceptualize these gaps as discrepancies between or among the four frames of identity and have conducted research among college students (both U.S.-born and international) as well as in community groups. Most empirical studies focused on the personal-enacted identity gaps and personal-relational identity gaps. Personal-enacted identity gaps refer to the inconsistencies found between an individual’s own views of his or her self and the identity he or she expresses. Similarly, a personal-relational identity gap is experienced when there are inconsistencies between an individual’s self-view and his or her perception of how others view him or her. Jung and Hecht (2004) and Wadsworth et al. (2008) found that these identity gaps were highly correlated with conversational inappropriateness and ineffectiveness as well as health outcomes such as depression.

### **COMMUNICATION THEORY OF IDENTITY AS A FRAMEWORK FOR DEVELOPING HEALTH MESSAGES**

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CTI not only helps in understanding health practices but also provides a framework for health message design (Hecht & Miller-Day, 2009; Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003; Roberto, Krieger, & Beam, 2009). Recent advances suggest that message strategies may be more effective when they target or focus on group membership (e.g., Schultz, Nolan, Cialdini, Goldstein, & Griskevicius, 2007) and/or are tailored or customized to the individual (e.g., Noar, Benac, & Harris, 2007). Here, we explain two strategies for applying CTI to health message design.

When researchers consider message design and delivery for a target audience, they need to reflect on the targeted individuals’ salient identity/ies. Because there are several types of identities, such as personal, enacted, relational, and communal, it is important to discover which identity is most relevant to the desired behavioral change in the specific context. One approach is to find the salient identity through formative research. Narrative interviews, for example, can

reveal the salient identities (e.g., tell me about a time when you . . .). As people discuss health challenges and choices, the relevant layer and identity typically emerge in their talk. In other situations, health scholars may design messages to evoke a particular identity in their target audience. Here, we explain how each layer might be used in message designs that evoke identities.

### *Personal Layer: You Will Be a Better Person*

One way to evoke personal identity in message design is through perceptions of self-efficacy, or the belief that one can successfully execute the learned behavior (Bandura, 1977), and through goal setting. This involves designing messages to make individuals set a goal in order to be “a better person” to achieve their own goals. For example, the message, “If you do x, you will be a better person” appeals to the idea that “I” want to be better and that by enacting a desired health behavior, which is promoted by health practitioners, “I” will attain this desired status. For instance, Fagerlin, Zikmund-Fisher, and Ubel (2007) used this strategy to motivate women to take contraceptives because they want to be “better persons” (e.g., having a better health status in the future) and they believed that they could be better by performing a certain behavior. However, the strategy of goal setting is unlikely to produce behavior change unless individuals perceive that they are capable of the behavior (e.g., self-efficacy in social cognitive theory [Bandura, 1991], perceived behavior control in the theory of planned behavior [Ajzen, 1991]). For example, one goal of *keepin’ it REAL*, the most widely disseminated middle school drug prevention program, is to teach how to effectively resist peer pressure to use drugs and ultimately how students can maintain the desired identity (Hecht, Marsiglia et al., 2003).

### *Enacted Layer: You Will Be Popular*

By asking individuals to show their personal and relational identities to others, researchers can promote individuals’ salient identities and reinforce desired change through public commitment. Other health messages can model desired behavior and enacted health identities. These messages can show that by enacting a certain identity through certain actions, individuals can claim a desired identity. This occurs, for example, when individuals wear pink ribbons to acknowledge themselves as breast cancer survivors or supporters in order to generate support to fight the disease. This allows people to enact a desired identity in a healthy or lower risk way: “People who exercise regularly are seen as healthy and youthful.”



### *Relational Layer: You Will Be a Better Family Member*

The relational layer can be utilized in a number of ways. One can call on identifications with salient relationships to encourage healthy behaviors. For example, parents rarely choose to jeopardize the health of their children (e.g., Rosenbaum & Murphy, 1990) and invoking effective parenting might be a strategy for promoting everything from smoking cessation to diet and exercise to safe storage of prescription medicines. The Strengthening Families Program, which focused on improving maternal parenting skills, showed promising findings such as decreased substance use by mothers even though mothers did not receive drug abuse treatment (Spoth, Redmond, & Shin, 2001).

Relational identities also can be sources of resistance to health messages that must be overcome. An individual who emphasizes an identity related to another person (e.g., a friend) who engages in unhealthy behavior, such as smoking, is unlikely to change the behavior (Falomir & Invernizzi, 1999). In this case it may be necessary to change the relational frame. For example, Harwood and Sparks (2003) recommend messages that encourage changing from identification as friend of someone engaging in unhealthy behaviors to identification as friend who engages in healthy behaviors. Another application might be the message, “If you do x, you will be a better family (or other group) member” among groups that value that membership. While those who identify with such a group may not be willing to change their behavior to promote their own health (personal identity), they may be willing to do so if the change is linked to their role in the family or other salient groups.

### *Communal Layer: Your Family/Group/Company Will Benefit*

Recently, health scholars have implemented prevention programs at the community level. That is, they have begun to focus on community-level change through interventions designed to build infrastructure, develop social capital, and promote healthy individuals within each community. A good example of the community approach is Communities That Care (CTC), “a prevention system that empowers communities to address adolescent health and behavior problems through a focus on empirically identified risks and protective factors” (Hawkins et al., 2008, p. 15). In the CTC system, individuals in a community select their leaders who, along with other community members, conduct a community assessment and, based on the findings, select evidence-based programs from a guided list to implement in their community. The assumption is that community members have specialized knowledge of their community and empowering them produces commitment that will lead to more lasting effects.

These programs are implemented by individuals who believe that whatever they are doing will help to improve their community. This strategy is particularly useful in close-knit groups and/or those in which ingroup/outgroup distinctions are salient. One can appeal to these memberships to promote change in ways that may not be possible through individualistic appeals.

Understanding the layers of identity can provide an organizing structure to these communal efforts. Although conceptualized at the communal level, many of the actual interventions target individuals, relationships (particularly families), and enactments. It may be profitable for approaches like CTC to begin to think about their efforts in this multilayered fashion.

### *Using Gaps to Motivate Change*

As noted above, one of the implications of the notion of “interpenetration” is that the layers may be in conflict with each other. Although identity gaps can threaten mental health and increase stress levels (Jung & Hecht, 2008; Jung et al., 2007), they also can be useful when they serve as a motivator in behavior change messages. According to cognitive dissonance theory (Festinger, 1957), individuals change behavior when cognitive inconsistency occurs. Particularly, Festinger, Riecken, and Schachter (1956) argued that dissonance is aroused when people are exposed to information that is inconsistent with their beliefs. In this case, messages can be designed to evoke incongruent identities and provide solutions or approaches that will reduce the inconsistency.

One good example is using identity gaps to change the normative belief of individuals. That is, by changing descriptive norms (e.g., beliefs about what most people do) and injunctive norms (e.g., beliefs about what people should do), health scholars can prevent problem behaviors. Successful school-based drug prevention programs change normative beliefs (e.g., Tobler et al., 2000). Adolescents usually identify themselves as “adolescent” (e.g., personal identity) and believe that they should use drugs because “many youths (e.g., communal identity)” use drugs. Messages that correct these descriptive norms (e.g., show them that fewer peers use, a common situation) and enhance injunctive norms discourage drug use (e.g., show them that peers disapprove drug use).

### **Conclusions and Directions for Future Research**

Although many empirical studies have shown that individuals’ identities are related to health behaviors and health-related beliefs, few researchers have scrutinized the identity theories such as the more complex and integrative

framework of CTI in order to incorporate identity strategies into health message design. In other words, there has been a long history of research on individuals' identities, but health message design scholars have only recently paid attention to a fuller conceptualization of identity such as that offered by CTI. Even when layers other than the personal have been considered, the approach does not always incorporate an identity framework. The Communities That Care (Hawkins, Catalano, & Arthur, 2002) is an example of a community-based approach that has not explicitly focused on communal identities nor has it conceptualized the targeted changes as layered. Application of a CTI-based message design may produce more comprehensive intervention, one of the frontiers in prevention research (Hecht & Krieger, 2006).

One use of CTI is the application of group-based identities such as race to message design. Much of the research about group-based identities and health behavior takes a demographical approach. That is, race is usually understood as a categorical identity in most practical applications, such as drug prevention programs (Hecht, Marsiglia et al., 2003) but this may not reflect the richness of the cultural identity (Hecht & Krieger, 2006) and, as a result, oversimplify or "gloss" identities in stereotypical ways.

The CTI frame has just begun to be studied at the empirical level. Although challenged by the complexity of the theory itself, we argue that CTI provides a valuable approach to studying health behaviors and designing health messages. These directions only hint at the richness of application that may come through CTI. Both conceptual and empirical work is needed to test and further develop CTI. Particularly, it is important to demonstrate how the four layers can be measured and how they relate to individual behaviors and collective structures. It is our intention that this chapter suggests directions for this work.

## References

- Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes*, 50, 179–211.
- Alexander, C., Piazza, M., Mekos, D., & Valente, T. W. (2001). Peer networks and adolescent cigarette smoking: An analysis of the National Longitudinal Study of Adolescent Health. *Journal of Adolescent Health*, 29, 22–30.
- Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavior change. *Psychological Review*, 84, 191–215.
- Bandura, A. (1991). Self-regulation of motivation through anticipatory and self-reactive mechanisms. In R. A. Dienstbier (Ed.), *Perspectives on motivation: Nebraska Symposium on Motivation* (Vol. 38, pp. 69–164). Lincoln: University of Nebraska Press.

- Banton, M. (1965). *Roles: An introduction to the study of social relations*. London: Tavistock.
- Barger, S. D., & Gallo, L. C. (2008). Ability of ethnic self-identification to partition modifiable health risk among US residents of Mexican ancestry. *American Journal of Public Health, 11*, 1971–1978.
- Baumeister, R. F. (1986). *Identity: Cultural change and the struggle for self*. New York: Oxford University Press.
- Ching, B. (2001). *Wrong's what I do best: Hard country music and contemporary culture*. New York: Oxford University Press.
- Cooley, C. H. (1902). *Human nature and the social order*. New York: Scribner.
- Fagerlin, A., Zikmund-Fisher, B., & Ubel P. A. (2007). "If I'm better than average, then I'm ok?": Comparative information influences beliefs about risk and benefits. *Patient Education and Counseling, 69*, 140–144.
- Falomir, J. M., & Invernizzi, F. (1999). The role of social influence and smoker identity in resistance to smoking cessation. *Swiss Journal of Psychology, 58*, 73–84.
- Faulkner, S. L., & Hecht, M. L. (2007). Tides in the ocean: A layered approach to culture and communication. In B. B. Whaley & W. Samter (Eds.), *Explaining communication: Contemporary theories and exemplars* (pp. 393–402). Mahwah, NJ: Lawrence Erlbaum.
- Festinger, L. (1957). *A theory of cognitive dissonance*. Stanford, CA: Stanford University Press.
- Festinger, L., Riecken, H. W., & Schachter, S. (1956). *When prophecy fails*. Minneapolis: University of Minnesota Press.
- Ford, L. A., & Christmon, B. C. (2005). Every breast cancer is different: Illness narratives and the management of identity in breast cancer. In E. B. Ray (Ed.), *Health communication in practice: A case study approach* (pp. 157–169). Mahwah, NJ: Lawrence Erlbaum.
- Goffman, E. (1967). *Interaction ritual*. New York: Pantheon.
- Hagger, M. S., & Orbell, S. (2003). A meta-analytic review of the common-sense model of illness representations. *Psychology & Health, 18*, 141–184.
- Harwood, J., & Giles, H. (2005). *Intergroup communication: Multiple perspectives*. New York: Peter Lang.
- Harwood, J., & Sparks, L. (2003). Social identity and health: An intergroup communication approach to cancer. *Health Communication, 15*, 145–159.
- Haslam, S. A., Jetten, J., Postmes, T., & Haslam, C. (2009). Social identity, health and well-being: An emerging agenda for applied psychology. *Applied Psychology: An International Review, 58*, 1–23.
- Hawkins, J. D., Brown, E. C., Oesterle, S., Arthur, M. W., Abbott, R. D., & Catalano, R. F. (2008). Early effects of Communities That Care on targeted risks and initiation of delinquent behavior and substance use. *Journal of Adolescent Health, 43*, 15–22.
- Hawkins, J. D., Catalano, R. F., & Arthur, M. W. (2002). Promoting science-based prevention in communities. *Addictive Behaviors, 27*, 951–976.

- Hecht, M. L. (1993). A research odyssey: Towards the development of a communication theory of identity. *Communication Monographs*, 60, 76–82.
- Hecht, M. L., Collier, M. J., & Ribeau, S. A. (1993). *African American communication: Ethnic identity and cultural interpretation*. Newbury Park, CA: Sage.
- Hecht, M. L., Jackson, R. L., II, & Ribeau, S. (2003). *African American communication: Exploring identity and culture* (2nd ed.). Mahwah, NJ: Lawrence Erlbaum.
- Hecht, M. L., & Krieger, J. L. (2006). The principle of cultural grounding in school-based substance abuse prevention. *Journal of Language and Social Psychology*, 25, 301–319.
- Hecht, M. L., Marsiglia, F. F., Elek-Fisk, E., Wagstaff, D. A., Kulis, S., Dustman, P., et al. (2003). Culturally-grounded substance abuse prevention: An evaluation of the *Keepin' it R.E.A.L.* curriculum. *Prevention Science*, 4, 233–248.
- Hecht, M. L., & Miller-Day, M. (2009). The Drug Resistance Strategies Project: Using narrative theory to enhance adolescents' communication competence. In L. Frey & K. Cissna (Eds.), *Handbook of applied communication* (pp. 535–557). New York and London: Routledge.
- Hecht, M. L., Warren, J., Jung, J., & Krieger, J. (2004). Communication theory of identity. In W. B. Gudykunst (Ed.), *Theorizing about intercultural communication* (pp. 257–278). Newbury Park, CA: Sage.
- Jung, E., & Hecht, M. L. (2004). Elaborating the communication theory of identity: Identity gaps and communication outcomes. *Communication Quarterly*, 52, 265–283.
- Jung, E., & Hecht, M. L. (2008). Identity gaps and level of depression among Korean immigrants. *Health Communication*, 23, 313–325.
- Jung, E., Hecht, M. L., & Wadsworth, B. D. (2007). The roles of identity in international students' psychological well-being: A model of depression level, identity gaps, discrimination, and acculturation. *International Journal of Intercultural Relations*, 31, 605–624.
- Kellner, D. (1992). Popular culture and the construction of postmodern identities. In S. Lash & J. Friedman (Eds.), *Modernity and identity* (pp. 141–177). Cambridge, UK: Blackwell.
- Kreuter, M. W., Lukwago, S. N., Bucholtz, D. C., Clark, E. M., & Sanders-Thompson, V. (2003). Achieving cultural appropriateness in health promotion programs: Targeted and tailored approaches. *Health Education and Behavior*, 30, 133.
- Krieger, J. L., Moreland, J., & Sabo, J. (2010, November). *Hillbilly or redneck? Linguistic stereotypes of rural Americans*. Paper presented to the Intercultural Division at the annual meeting of the National Communication Association, San Francisco.
- Lin, E. (2008). Family and social influences on identity conflict in overseas Chinese. *International Journal of Intercultural Relations*, 32, 130–141.
- Mead, G. H. (1934). *Mind, self, and society from the standpoint of a social behaviorist*. Chicago: University of Chicago Press.

- Ndiaye, K., Krieger, J. L., Warren, J. R., Hecht, M., & Okuyemi, K. (2008). Health disparities and discrimination: Three perspectives. *Journal of Health Disparities and Research, 2*, 51–71.
- Noar, S. M., Benac, C. N., & Harris, M. S. (2007). Does tailoring matter? Meta-analytic review of tailored print health behavior change interventions. *Psychological Bulletin, 133*, 673–693.
- Roberto, A. J., Krieger, J. L., & Beam, M. A. (2009). Enhancing web-based kidney disease prevention messages for Hispanics using targeting and tailoring. *Journal of Health Communication, 14*, 525–540.
- Rosenbaum, M., & Murphy, S. (1990). Women and addiction: Process, treatment, and outcome. In E. Y. Lambert (Ed.), *The collection and interpretation of data from hidden populations* (Research Monograph 98, pp. 127–145). Washington, DC: National Institute on Drug Abuse.
- Schlenker, B. R. (1985). Introduction: Foundations of the self in social life. In B. R. Schlenker (Ed.), *The self and social life* (pp. 1–28). New York: McGraw-Hill.
- Schultz, P. W., Nolan, J. M., Cialdini, R. B., Goldstein, N. J., & Griskevicius, V. (2007). The constructive, destructive, and reconstructive power of social norms. *Psychological Science, 18*, 429–434.
- Spoth, R. L., Redmond, C., & Shin, C. (2001). Randomized trial of brief family intervention for general populations: Adolescent substance use outcome 4 years following baseline. *Journal of Consulting and Clinical Psychology, 69*, 627–642.
- Tajfel, H., & Turner, J. (1986). The social identity theory of intergroup behavior. In S. Worchel & W. Austin (Eds.), *Psychology of intergroup relations* (2nd ed., pp. 7–24). Chicago: Nelson Hall.
- Thoits, P. A. (1992). Identity structures and psychological well-being: Gender and marital status comparisons. *Social Psychology Quarterly, 55*, 236–256.
- Tobler, N. S., Roona, M. R., Ochshorn, P., Marshall, D. G., Streke, A. V., & Stackpole, K. M. (2000). School-based adolescent drug prevention programs: 1998 meta-analysis. *Journal of Primary Prevention, 20*, 275–336.
- Turner, J. C. (1991). *Social influence*. Milton Keynes, UK: Open University Press.
- Umberson, D. (1992). Gender, marital status and the social control of health behavior. *Social Science & Medicine, 34*, 907–917.
- Urberg, K. A., Degirmencioglu, S. M., & Pilgrim, C. (1997). Close friend and group influence on adolescent cigarette smoking and alcohol use. *Developmental Psychology, 33*, 834–844.
- Wade, J. C. (2008). Masculinity ideology, male reference group identity dependence, and African American men's health-related attitudes and behaviors. *Psychology of Men & Masculinity, 9*, 5–16.
- Wadsworth, B. C., Hecht, M. L., & Jung, E. (2008). The role of identity gaps, discrimination, and acculturation in international students' educational satisfaction in American classrooms. *Communication Education, 57*, 64–87.

## Notes

1. It may be advantageous to separate these into three different layers. For the sake of parsimony, the three properties of the relational are combined into a single layer.

2. Some have suggested that there are personal, enacted, relational, and communal identities at both individual and communal levels (Hecht, Warren, Jung, & Krieger, 2004). That is, individuals identify through defining self (personal/individual), enacting identities (enacted/individual), seeing themselves through relationships (relational/individual), and through group memberships (group/individual). At the same time, there are communal definitions of selves (personal/communal), enactments (enacted/communal), relationships (relational/communal), and groups (group/communal). One advantage of this formulation is that it explicitly focuses on group memberships on an individual level. However, we retain the original formulation in this chapter for parsimony.

## Suggested Additional Readings

Hecht, M. L., & Faulkner, S. L. (2000). Sometimes Jewish, sometimes not: The closeting of Jewish American identity. *Communication Studies*, 51, 372–387.

Hecht, M. L., Faulkner, S. L., Meyer, C. R., Niles, T. A., Golden, D., & Cutler, M. (2002). Looking through *Northern Exposure* at Jewish American identity and the communication theory of identity. *Journal of Communication*, 52, 852–870.

Hecht, M. L., Jackson, R. L., II, Lindsley, S., Strauss, S., & Johnson, K. E. (2001). A layered approach to ethnicity: Language and communication. In W. P. Robinson & H. Giles (Eds.), *The new handbook of language and social psychology* (pp. 429–449). Chichester, UK: Wiley.

Kam, J. A., & Hecht, M. L. (2009). Investigating the role of identity gaps among communicative and relational outcomes within the grandparent–grandchild relationship: The young-adult grandchildren’s perspective. *Western Journal of Communication*, 73, 456–480.

## Questions for Theory and Practice

1. What does it mean when we say that identity is “layered”? Why is this important for health message design?
2. Define each layer of your identity. Explain how someone might design a message to influence your health behaviors using each.

3. Define “identity gap.” Have you ever experienced one? If so, what implications do you think this had for your health?
4. How might online identities (e.g., avatar) be used in message design?
5. What may be potential unintended effects when messages are designed based on CTI?