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Re-Shaping our Vision of Intimate Partner Violence: A Qualitative Analysis of Survivors' Reaction to Existing Campaigns

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ABSTRACT

According to the Centers for Disease Control and Prevention (2003), an estimated 5.3 million incidents of intimate partner violence (IPV) occur each year in the United States, resulting in nearly 2 million injuries, and approximately 1,300 deaths. Additionally, The National Intimate Partner and Sexual Violence Survey (2011) found that 1 in 3 women (35.6%) have experienced sexual and/or physical violence at the hands of an intimate partner. More attention has been paid to IPV in the past two decades, resulting in an increase in the number of prevention and intervention mass media campaigns; however, very few campaigns report consulting survivors of IPV (Keller & Otjen, 2007). Given the prevalence of IPV in the U.S., and the increased efforts to reach victims through mass media campaigns, the present study will focus on the lived experiences of survivors of IPV and how they react to current campaign ads in a focus group setting. Using the Health Belief Model (HBM) as a theoretical framework, this study seeks to better understand the experiences of survivors, and how those experiences shape the way they view prevention and intervention ads. These interviews provide insight into the diverse lived experiences of survivors of IPV, and have implications for women, social science research, educators, advocates, and the general public.
DEDICATION

This thesis is dedicated to my friend, Rose, who was brave enough to leave, but paid the ultimate price for that decision. Her courage in trying to build a better life for herself inspired this project. Through her death came the opportunity to allow survivors to bravely share their stories, contributing to our understanding of, and knowledge about, intimate partner violence, and further strengthening our commitment to end the abuse.
ACKNOWLEDGMENTS

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TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>TITLE PAGE .................................................................</td>
</tr>
<tr>
<td>ABSTRACT ...........................................................................</td>
</tr>
<tr>
<td>DEDICATION ........................................................................</td>
</tr>
<tr>
<td>ACKNOWLEDGMENTS ...........................................................</td>
</tr>
<tr>
<td>LIST OF TABLES ..................................................................</td>
</tr>
<tr>
<td>LIST OF FIGURES ................................................................</td>
</tr>
<tr>
<td>CHAPTER</td>
</tr>
<tr>
<td>I. INTRODUCTION ..................................................................</td>
</tr>
<tr>
<td>Intimate Partner Violence ................................................</td>
</tr>
<tr>
<td>Abuse and Power ...............................................................</td>
</tr>
<tr>
<td>Mass Media Public Health Campaigns ...................................</td>
</tr>
<tr>
<td>IPV Public Health Campaigns .............................................</td>
</tr>
<tr>
<td>Statement of the Problem ..................................................</td>
</tr>
<tr>
<td>Rationale and Purpose of Study .........................................</td>
</tr>
<tr>
<td>Theoretical Framework .....................................................</td>
</tr>
<tr>
<td>Overview ............................................................................</td>
</tr>
<tr>
<td>II. LITERATURE REVIEW ....................................................</td>
</tr>
<tr>
<td>Intimate Partner Violence ................................................</td>
</tr>
<tr>
<td>Forms of IPV .......................................................................</td>
</tr>
<tr>
<td>Physical Effects of IPV ....................................................</td>
</tr>
<tr>
<td>Psychological Effects of IPV .............................................</td>
</tr>
<tr>
<td>Public Health Campaign Design ...........................................</td>
</tr>
<tr>
<td>Future Direction of Campaign Design ..................................</td>
</tr>
<tr>
<td>Stigmatized Issues in Public Health Campaigns ....................</td>
</tr>
<tr>
<td>IPV Public Health Campaigns .............................................</td>
</tr>
<tr>
<td>Health Belief Model ..........................................................</td>
</tr>
<tr>
<td>Overview ............................................................................</td>
</tr>
</tbody>
</table>
Table of Contents (Continued)

<table>
<thead>
<tr>
<th>III. METHODS</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research Questions</td>
<td>54</td>
</tr>
<tr>
<td>Methodological Paradigm</td>
<td>54</td>
</tr>
<tr>
<td>Multiple Methods</td>
<td>55</td>
</tr>
<tr>
<td>Researcher’s Standpoint</td>
<td>57</td>
</tr>
<tr>
<td>Protection of Human Subjects</td>
<td>58</td>
</tr>
<tr>
<td>Research Design</td>
<td>60</td>
</tr>
<tr>
<td>Data Collection</td>
<td>60</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>62</td>
</tr>
<tr>
<td>Methods Summary</td>
<td>67</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IV. RESULTS</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>RQ1: Lived Experiences</td>
<td>71</td>
</tr>
<tr>
<td>RQ1a: Motivations for Seeking Support</td>
<td>79</td>
</tr>
<tr>
<td>RQ2: Perceptions of Current and Former IPV Campaign Ads</td>
<td>84</td>
</tr>
<tr>
<td>RQ3: Perceptions of Current &amp; Former Campaign Ads</td>
<td>91</td>
</tr>
<tr>
<td>RQ4: Depiction of Ideal Ad</td>
<td>96</td>
</tr>
<tr>
<td>Results Summary</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>V. DISCUSSION</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpretation of RQ1: Lived Experiences</td>
<td>102</td>
</tr>
<tr>
<td>Interpretation of RQ1a: Motivations for Seeking Support</td>
<td>105</td>
</tr>
<tr>
<td>Interpretation of RQ2: Perceptions of Campaign Ads</td>
<td>106</td>
</tr>
<tr>
<td>Interpretation of RQ3: Perceptions of Ads Based on HBM</td>
<td>109</td>
</tr>
<tr>
<td>Interpretation of RQ4: Depiction of Ideal Campaign Ad</td>
<td>112</td>
</tr>
<tr>
<td>Limitations</td>
<td>113</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VI. CONCLUSION</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>REFERENCES</td>
<td>118</td>
</tr>
<tr>
<td>APPENDICES</td>
<td>145</td>
</tr>
<tr>
<td>A: Interview Script</td>
<td>146</td>
</tr>
<tr>
<td>B: Campaign Ads</td>
<td>150</td>
</tr>
</tbody>
</table>
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Lived Experiences</td>
<td>72</td>
</tr>
<tr>
<td>2</td>
<td>Motivations for Seeking Support</td>
<td>80</td>
</tr>
<tr>
<td>3</td>
<td>Perceptions of Current and Former IPV Campaign Ads</td>
<td>85</td>
</tr>
<tr>
<td>4</td>
<td>Perceptions of Current and Former IPV Campaign Ads in Relation to Components of HBM</td>
<td>92</td>
</tr>
<tr>
<td>5</td>
<td>Depiction of Ideal Campaign Ad</td>
<td>96</td>
</tr>
</tbody>
</table>
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Choices 1 and 2</td>
<td>97</td>
</tr>
<tr>
<td>2</td>
<td>Hell</td>
<td>98</td>
</tr>
<tr>
<td>3</td>
<td>Love Doesn’t Hurt</td>
<td>100</td>
</tr>
</tbody>
</table>
CHAPTER ONE

INTRODUCTION

For the past three decades, health communication has risen steadily as a field of social scientific research, education, and application (Kreps, 2011a; Kreps & Bonaguro, 2009; Kreps, Bonaguro, & Query, 1998). This research incorporates the disciplines of communication, psychology, sociology, public health, organizational behavior, medicine, and other related fields (Kreps & Maibach, 2008). The field of health communication covers several areas of inquiry including, communication during the delivery of care, health promotion, e-health, health risk information, and health care system operations (Kreps, 2011b). There are two main branches of health communication research: healthcare delivery and health promotion (Kreps et al., 1998). The first, healthcare delivery, is concerned with how communication influences how messages are crafted, delivered, and received by patients. The second branch, health promotion, focuses on the use of persuasive communication messages and media in an effort to promote effective public health. The second branch is the focus of the present study.

Health communication delves into the influences of both human and mediated communication in the sectors of healthcare and health promotion (Kreps & Bonaguro, 2009). The goal of health communication research is to “facilitate improvements in the delivery of care and the promotion of health, ultimately enhancing health outcomes” (Kreps & Maibach, 2008; Parrott, 2008). Kreps (2012) voices his concern about the direction of health communication inquiry, noting a clear gap between the work scholars...
undertake to report their research and how scholars actually apply the results of that research to improve health-promoting practices and policies. There exists a strong need to bridge this gap in all areas of health research, but particularly in the realms of safer sexual practices (Kreps, 2012), cancer risk reduction (Hertog et al., 1993) and Intimate Partner Violence (IPV; West, 2013).

The Centers for Disease Control and Prevention (CDC; 2011) define IPV as “physical, sexual, or psychological harm by a current or former partner or spouse [that] can occur among heterosexual or same-sex couples and does not require sexual intimacy.” IPV can come in the form of physical violence, sexual violence, threats, and/or emotional abuse (CDC, 2012). The National Intimate Partner and Sexual Violence Survey (2011) found that 1 in 3 women (35.6%) have experienced sexual and/or physical violence at the hands of an intimate partner. Further, this study found that 48.4% of all women in the United States have been the victims of psychological abuse by their intimate partner.

IPV is a community health problem, affecting the victim directly, but affecting society at large as well. IPV costs society approximately $5.8 billion every year, with $4.1 billion going towards medical costs and mental health services, and the remaining going towards lost wages and loss in productivity, among other things (NCADV, 2007). Victims of IPV experience a wide range of physical and emotional repercussions including, cuts, bruises, broken bones, flashbacks, panic attacks, and reduced self-esteem (CDC, 2012). Furthermore, victims of IPV are at risk for future poor health behaviors including, smoking, drinking, taking drugs, and engaging in risky sex (CDC, 2012). The
sheer magnitude of this public health issue denotes its need for further exploration in efforts to curb the problem, and in order to do so, needs to be examined from a communication perspective.

Communication campaigns are often seen as a way of educating the public about a particular phenomena and providing them information as to how they should feel or act towards the particular phenomena. In health communication, these campaigns target a particular health issue and are concerned with convincing the public either to cease a harmful health behavior or to introduce a beneficial behavior into their lives (Randolph & Viswanath, 2004). Health communication campaigns are particularly important in life-threatening health issues such as IPV, given their emphasis on behavior change, particularly through the use of fear appeals to promote preventative health behavior (Witte, 1994).

The Health Belief Model (HBM; Janz & Becker, 1984; Rosenstock, 1974) is one of the most widely used models for health behavior change. Health professionals frequently consult this model in order to guide the development of intervention and campaign efforts (Witte, Meyer, & Martell, 2001). The HBM was originally developed as a means for promoting preventative health behaviors by social psychologists working for the U.S. government in the 1950s (Janz & Becker, 1984). This model suggests that preventative health behavior is influenced by five key factors: perceived barriers to the recommended health response, perceived benefits to the recommended health response, perceived susceptibility to the health threat, perceived severity of the health threat, and cues to taking preventative action (Witte, Meyer, & Martell, 2001). Using the HBM to
guide research design, the present study seeks to better understand the experiences of victims of IPV, and how those experiences shape the way they view domestic violence prevention and intervention campaigns.

**Intimate Partner Violence**

The CDC (2012) denotes four types of behavior that constitute IPV. First, physical violence occurs when one person hurts or attempts to hurt their partner by hitting, kicking or using some other act of physical force. Sexual violence occurs when one partner forces another to engage in a sex act without that partner’s consent. Threats of physical or sexual violence can include the use of words, gestures, weapons, or other ways of communicating the intention to cause harm. Finally, emotional abuse occurs when one partner threatens the other or his or her possessions or loved ones. Examples of emotional abuse are stalking, name-calling, intimidation, and seclusion from family or friends.

An estimated 5.3 million incidents of IPV occur each year in the United States, resulting in nearly 2 million injuries, and approximately 1,300 deaths (CDC, 2003). In 2007, IPV deaths accounted for 14% of all homicides in the U.S. (CDC, 2012). The National Intimate Partner and Sexual Violence Survey (NISVS; 2011) found that nearly half (48.4%) of all women in the U.S. have experienced some form of psychological abuse by an intimate partner, and 4 in 10 women reported acts of expressive aggression (i.e., their partner reacted in a way that seemed dangerous, verbally belittled or humiliated them) by their intimate partner. According to the U.S. Department of Justice (2012), women between the ages of 18-24 and 25-34 are at the greatest risk for IPV.
Victims of IPV are subject to both mental and physical health repercussions, and previous studies have found that victims make more frequent trips to healthcare providers, have longer hospital stays, and are at more risk for a wide-range of health consequences than their counterparts who are not abused (Basile & Smith, 2011; Black, 2011). Women who are victims of IPV are more susceptible to long-term health effects, such as mental illness, specifically depression and posttraumatic stress disorder, substance abuse, chronic pain, sexually transmitted diseases, and perinatal complications (Feder et al., 2006).

IPV is a public health phenomenon that can affect anyone, no matter gender or sexual orientation, but some groups are at higher risk of IPV than others. Prior research has overwhelmingly indicated that women face a substantially higher risk of becoming a victim of IPV than do men (CDC, 2012; DOJ, 2012; NCADV, 2007; Tjaden & Thoennes, 2000). Data indicate 3 in 10 women and 1 in 10 men will experience rape, physical violence, and/or stalking at the hands of an intimate partner (CDC, 2012). Additionally, women are significantly more likely than men to be injured during an act of intimate partner violence, with 39% of women and 24.8% of men reporting injuries in their most recent physical assault (Tjaden & Thoennes, 2000). Researchers suggest the reason for the discrepancy in numbers lies in a man’s need to exert total control over their partner, and his feelings of frustration and anger when that control appears to be slipping (Johnson, 2008; Dutton 1988). Historical attitudes towards power in a marriage have made it so that husband’s had the right, and were expected, to exert power and control over their wives, even if that meant using physical violence (Dobash & Dobash, 1977).
The present study is concerned with the experiences of IPV as perceived by women; men’s experiences were not examined.

Abuse and Power

In 1947, Webster (as cited in Murphy & Meyer, 1991) described power as the “probability that one actor within a social relationship will be in a position to carry out his own will despite resistance” (p. 152). The root causes of violence exhibited by one spouse towards the other are power and control, making it unsurprising that abusers are overwhelmingly men who are the products of a society rooted in a patriarchal belief system that supports, and even encourages, male dominance over others. Gilbert and Webster (1982) claim that in a patriarchal society, power is considered the reward for doing masculinity well, and powerlessness the reward for doing femininity well. Though men, in lesser numbers, have experienced abuse by an intimate partner, they likely experience that abuse differently than women due in part to the fact that the two genders have been socially conditioned to experience culture in different ways (Marshall, 1993). A contributing factor to the differences in the way each gender experiences abuse lies in the perceptions of power in men as opposed to women. Sex is a telltale characteristic of perceived social power, which can be seen in men’s disproportionate advancement in areas of social, political, and economic power over women (Basow, 1986). Society has conditioned men to think that it is acceptable behavior to exert power and control over others. Dobash and Dobash (1979) explain that men who resort to physical means of controlling their wives “are actually living up to cultural prescriptions that are cherished in Western society-aggressiveness, male dominance, and female subordination, and they
are using physical violence as a means of displaying the dominance they hold over women” (p. 24).

Gender-linked styles of power provide insight into the issue of violence, and provide a contextual framework for aiding the understanding of differences in male and female acts of aggression. Yoder and Kahn (1992) identify two types of power manifestations and note how they are differentiated by gender. “Power-over” refers to one person’s ability to have influence over another or to get them to change their actions (Ragins & Sundstrom, 1989). “Power-to” on the other hand refers to personal empowerment, to the control of one’s personal thoughts, feelings, and behaviors (Bandura, 1989). In general, men exhibit the “power-over” style, and women exhibit the “power-to” style (Yoder & Kahn, 1992).

Society continues to contribute to the blatant gender inequalities that have perpetuated for centuries, and as Serran and Firestone (2004) note, “the law and patriarchal hierarchy have legitimized wife beating and control, resulting in unequal power relationships between men and women” (p. 12). As such, men are free to exhibit the “power-over” style in part because history says they are the dominant sex, and because this hierarchal system is rarely challenged. Several patriarchal beliefs continue to contribute to IPV: (1) the husband may decide whether or not his wife will work outside of the home; (2) the husband has the right to decide if his wife can leave home after dark; (3) it is important for the husband to demonstrate that he is head of the household; and (4) the husband has the right to demand sex from his wife even if she is not interested (Myers, 1995; O’Toole & Schiffman, 1997; Smith, 1990). Hornung, McCullough, and
Sugimoto (1981) found that women with higher-status jobs than their husbands were more likely to experience some form of life-threatening IPV than were women whose jobs were on a similar scale with their husband’s. When considering issues such as rape and IPV, scholars must focus less on explanations of individual behavior and more on these acts as a continual perpetuation of male domination over women; that is, men’s exertion of power over women (Yoder & Kahn, 1992).

This overview brings to light the importance of studying IPV as a pervasive public health issue adversely affecting a large percentage of the U.S. population. Given the widespread prevalence of IPV in the U.S., public health officials have turned to mass media public health campaigns as a means to reach potential victims. Examining the design and implementation of these campaigns aids in our understanding of the effectiveness of their messages to potential victims of serious health issues such as IPV.

**Mass Media Public Health Campaigns**

Public communication campaigns were in existence before the advent of the U.S. federal government (Paisley, 2001). Examples from the 1700s include Cotton Mather and public inoculations, Benjamin Franklin and abolitionism, Thomas Paine and independence, and Dorothea Dix and the mentally ill (Rice & Atkin, 2009). The 1800s brought with them some changes, as legislative testimony, mass communication, confrontation, and local organizing (Rice & Atkin, 2009) were used to promote abolitionism, women’s suffrage, temperance unions, and wilderness preservation (Rice & Atkin, 2009). By the mid-twentieth century, campaign designers began using social scientific techniques to develop and evaluate their campaigns; with early opinions stating
that mass media campaigns had little to no effect on their targeted audience, and that those audiences were uninterested, with more recent theories positing that well-designed campaigns are capable of producing moderate success if they employ a proportionate mix of social change, media advocacy, community involvement, audience targeting, message design, channel use, and time frames (Rice & Atkin, 2009).

Public health campaigns are the most common form of purposeful use of mass media with the intention of public health promotion (Keller & Brown, 2002). The first public health campaigns were designed with the idea that as human beings, we want nothing more than our own personal health and longevity (du Pré, 2014). Campaigns aimed at promoting healthy behaviors and discouraging unhealthy behaviors have long been used in an effort to improve the health of the general public (Hornik, 2002).

Although this practice has existed for centuries, it remains difficult to measure the effectiveness of these campaigns with any degree of certainty (Hornik, 2002). Most simply, mass media campaigns are designed in order to influence the normal trend in the information that is currently available and being disseminated on the given health topic (Viswanath et al., 1991). Rogers and Storey (1987) conducted a comprehensive review of health communication campaigns and found four overarching elements: (1) a campaign is designed in order to elicit specific outcomes or effects (2) in a large percentage of the population (3) within a specific period of time and (4) through specific communication practices.

In the first meta-analysis of U.S. public health campaigns, Snyder and Hamilton (2002) found that (1) campaign success varied depending on the topic, with seatbelt, oral
health, and alcohol campaigns having the most success; (2) campaigns focused on the adoption of a new health behavior found more success than did those advocating for the prevention or cessation of a particular behavior; and (3) greater effects were found in campaigns with a wider reach/more audience exposure than those with more limited reach/exposure. Snyder and Hamilton’s (2002) results are supported by a long-standing alcohol education campaign at Rutgers University. One of the most famous mass media public health campaigns RU SURE was created at Rutgers in the 1990s, and designed to curb the high rates of dangerous alcohol consumption amongst college students (du Pré, 2014). The ongoing success of this campaign is attributed, in part, to its high level of student involvement and creative ways of immersing campaign messages in with everyday campus life (du Pré, 2014). Professor and director of the Rutgers Center for Communication and Health Issues, Lea Stewart, explains the importance of the communication discipline to this campaign: “Communication majors are involved in all aspects of this campaign, from designing ways to deliver campaign messages to gathering evaluation data” (du Pré, 2014, p. 366). In addition to strategies derived from the field of communication, public health campaigns must also employ social marketing strategies. In doing so, campaign designers apply principles of commercial advertising to pro-social campaigns, such as those aimed at health promotion (Lefebvre & Flora, 1988). In designing campaigns from this perspective, market researchers determine the wants, needs, and desires of the intended audience and design, or market, their campaign to meet those needs (Witte, Meyer, & Martell, 2001). Social marketing campaigns are more often than not large-scale campaigns intended to reach a certain percentage of the population.
IPV Public Health Campaigns

Given the high prevalence of IPV, and the newfound recognition of its detrimental effects on health and productivity, efforts have been made in the last two decades to assist victims in both reporting the abuse and in receiving care after-the-fact. Both government and nonprofit agencies have put considerable efforts into forms of social marketing (e.g., mass media campaigns, educational kits, support groups, and helplines) in an effort to brand IPV as unacceptable and inexcusable behavior (Cismaru & Lavack, 2010). Campaigns range in size, budget, targeted audience, and location. Campaigns often have a variety of objectives, including: raising awareness of IPV and available resources; advice for victims, perpetrators, professionals, and bystanders; and changing societal attitudes and beliefs that tend to normalize the abuse (Cismaru & Lavack, 2010).

IPV interventions usually come in one of three forms: shelters for survivors, hotlines, and informational services (Gosselin, 2010). Because most responses to IPV come in the form of intervention after the abuse has already occurred, those working in the field face the arduous task of determining the best way to communicate to victims the resources available to them (Keller et al., 2010). Public health campaigns are often used to reach a wider segment of the population and are designed with the intent to empower victims to escape their abuser (Keller et al., 2010). These campaigns come in the form of public service announcements and advertisements, and usually provide their audience with information concerning warning signs of IPV and available community resources (Keller et al., 2010). While the majority of IPV public health campaigns have as their
target audience victims of the abuse, few of these studies actually cite having consulted victims during the formative research process (Keller & Otjen, 2007). Formative research, or formative evaluation, is a crucial step in any campaign design process, as this stage provides designers with data and perspectives useful in improving message content throughout the design phase (Atkin & Freimuth, 2001; Flora, 2001). A comprehensive review of IPV public health campaigns from 1991-2001 found that the majority of campaigns were clinic-based, and although there were some interventions aimed at public education, very few were systematically evaluated (Keller et al., 2010). One such study failed to adequately consult victims of IPV prior to campaign design, and when concerned that their campaign would incite feelings of victim blaming, campaign designers decided they knew how best to assuage the potential backlash, without ever having confirmed their beliefs with the source (Keller & Otjen, 2007). This type of decision-making power residing in the hands of campaign researchers and designers is typical of public health mass media campaigns, most especially when dealing with sensitive subjects such as IPV.

Silenced voices. Historically, female voices have been subordinate to dominant male voices, resulting in a group of society that is literally and metaphorically silenced, or at the very least, muted by the opposite sex. Women can be considered a muted group of society due in part to the fact that their perceptions cannot be stated, or easily expressed, within the confines of the dominant male society (Kramarae, 1981). Women’s voices and opinions are largely underrepresented by historians, linguists, anthropologists, speechwriters, news reports, and businessmen, to name a few (Kramarae, 1981). Further,
mass media have the tendency to frame stories in such a way as to perpetuate the patriarchal structure within society, as well as to create distorted pictures of certain sensitive topics, such as IPV (Bullock & Cubert, 2003).

In patriarchal societies, such as the one we live in today, women constitute a subset of the population that is often forgotten, underrepresented, or misinterpreted in comparison with the more dominant social groups (Burnett et al., 2009). Society has been conditioned to value masculine traits and the male voice more so than female traits and the female voice. In this way, women are actively devalued in our society (Murphy & Meyer, 1991; Myers, 1995). The dominant cultural group determines the communicative strategy for everyone, leaving subordinate groups no option but to acquiesce to the communicative demands of the larger group (E. W. Ardener, 1978; S. Ardener, 1975). In this way, the subordinate group, women, are forced to alter their own communicative strategies so as to participate in the discourse style set by the dominant group (Henley & Kramarae, 1994; Kramarae, 1981; Orbe, 1998b, 2005).

In an effort to give voice to women silenced by the dominant social group, Burnett et al. (2009) call for the exploration of women’s experiences generally excluded from dominant scholarly research. While scholars have certainly explored the issue of IPV in depth, and even consulted survivors of IPV to a certain extent, the problem lies in the fact that as the subordinate group, women have been conditioned to use the language of the dominant group in what they consider to be the appropriate communication strategy necessary in order to actively participate in a male-dominated society (E. W. Ardener, 1978; S. Ardener, 1975; Henley & Kramarae, 1994; Kramarae, 1981; Orbe,
In this way, consulting women in general, and especially survivors of IPV, through generic means such as surveys and questionnaires, is yet again preventing them from telling their experiences in their own words. As Kramarae (1981) explains, “experiences peculiar to the subordinate group have not yet been encoded in a language” (p. 7). In order to counteract this trend, women must be given the appropriate platform and channel through which to tell their story in their own words. Even when given the opportunity to share their stories, women are still partly silenced due to male-controlled media, the ways their bodies are portrayed and scrutinized, and through censorship of their voices (Houston & Kramarae, 1991). When it comes to such issues as IPV, it is crucial that survivors be allowed the opportunity to tell their stories so as to help other women in similar situations. This rarely happens, however, as women are considered the subordinate group, resulting in an overall dismissal of their voices and opinions by those in dominant positions. Women’s knowledge is not considered sufficient enough to have input in public decision-making or policy-making practices of the dominant culture (Kramarae, 2005). In addition, Kramarae (2005) notes that women’s experiences are somehow not their own, and are interpreted for them by third parties. This is exemplified in the prevention and intervention techniques aimed at reducing incidents of IPV in the United States.

Overall, there is a clear underrepresentation of women’s voices in mass media, particularly on serious health-related subjects such as IPV. This problem is further exacerbated by a lack of research into IPV mass media campaigns and how women react
to such campaigns. The present study endeavors to add to the nascent body of literature examining women’s voices on the subjects of IPV and mass media health campaigns.

**Statement of the Problem**

IPV is a widespread public health phenomenon in the U.S. that continues to affect women despite legislation aimed at curbing the incidents. Although both men and women are affected by IPV, research suggests women are overwhelmingly the victims (NCADV, 2007). IPV leads to both physical and mental health issues for women. Effects of IPV include, bodily injuries, poor physical health, low self-esteem, depression, anxiety, and increased desire to leave the relationship (Johnson, 2008). Sutherland (1999) investigated long-term effects of IPV on victims and discovered that psychological aspects of IPV have longer lasting adverse health consequences than do physical ones.

Presently, there exists a gap in health communication research and applying that research towards initiatives to improve public health outcomes (Kreps, 2012). More specifically, and of particular interest to the present study, there exists a substantial disconnect in campaigns designed for the prevention and intervention of IPV and the effects of those campaigns on their target audience: victims of the violence (West, 2013). A recent study suggested that campaigns designed to help victims of IPV have actually only succeeded in further psychological harm that worked only to increase the anger and hopelessness victims were already experiencing (West, 2013).

While research studies centering on IPV have increased exponentially in recent years, only a small fraction of these studies actually consult survivors of IPV as to the most effective ways of reaching an abused and imparting the message that there is help
available. Scholars have certainly explored the topic of IPV prevention and intervention campaigns, and some have even tested these campaigns, but these messages are not being tested with the appropriate audience. One such campaign designed and tested fear appeal messages with potential victims of IPV, and those “not directly involved in abuse but [who] might have friends or relatives who are victims” (Keller & Otjen, 2007, p. 237).

Potential victims of IPV do not have the same experiences to draw upon, and as a result, cannot communicate the process victims of IPV experience. Only survivors can accurately describe the processes and actions of what they went through, and finally, only survivors can provide a raw reaction to campaign ads because only they have experienced the phenomenon.

**Rationale and Purpose of Study**

The intent of the present study is to give survivors of IPV a platform on which to voice their first-hand experiences and to provide feedback on existing domestic violence campaigns based on those experiences. Thus, the purpose of this study is to explore and describe the communicative reactions of survivors of IPV to domestic violence prevention and intervention campaign advertisements, or ads. Further, this study aims to generate an overarching explanation for how survivors interpret these ads.

While research examining the issue of IPV is abundant, studies that seek to understand the lived experiences of survivors in their own words are minimal. In addition, previous studies investigating survivors’ reaction to IPV campaigns are scant. The present study seeks to contribute to the minimal amount of literature investigating survivors’ reactions of IPV campaign ads, and furthermore, seeks to influence campaign
design in the future. This study aims to achieve the goal of providing a “unified theoretical explanation” (Corbin & Strauss, 2007, p. 107) for survivors’ reactions to IPV campaigns and how to improve those campaigns in the future.

This study specifically responds to Murray-Johnson & Witte’s (2009) call to investigate how components of the HBM (i.e., perceived susceptibility, perceived severity, perceived benefits of preventive action, and perceived barriers to preventive action) relate to the outcome of the audience’s attitudes, intentions, and behavior towards the recommended health behavior. Further, this study builds on previous research examining overall reactions of survivors to prevention and intervention campaigns in an effort to expose the failure of these campaigns to reach their target audience. As a result, the experiences of these survivors will hopefully be used as a guide for developing a theory or model, to design future IPV campaigns that effectively reach their target audience.

**Theoretical Framework**

Health communication research has made use of the Health Belief Model (HBM) in numerous studies (Hochbaum, 1958). The model, originally developed in the 1950s by social psychologists seeking to determine why people failed to take part in programs designed for the prevention and detection of tuberculosis, was then expanded in 1974 to include symptoms and behavioral response (Rosenstock, 1974). The findings of a decade-long review reinforce the decision to utilize this model in IPV research (Becker, 1974; Janz & Becker, 1984). The review found, “perceived barriers were the most powerful single predictor,” and in addition, “perceived susceptibility was a stronger predictor of
preventative health behavior than sick-role behavior” (Champion & Skinner, 2008, p. 50). Rosenstock, Strecher, and Becker (1988) divide the HBM into three sections, the first of which calls for the “existence of sufficient motivation” in order for a particular health issue to be relevant to a person (Rosenstock et al., 1988, p. 177). Second, in order for action to occur, a person must believe that they are susceptible to that problem. Finally, there must exist the “belief that following a particular health recommendation would be beneficial in reducing the perceived threat,” while also overcoming the perceived barriers to that health treatment (Rosenstock et al., 1988, p. 177).

Understanding the six constructs of the HBM is essential to understanding results of past studies using the model. The six constructs include: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy. The first component, perceived susceptibility, refers to the “belief about the chances of experiencing a risk or getting a condition or disease.” Second, perceived severity is defined as the “belief about how serious a condition and its sequelae are.” The third component to the HBM, perceived benefits, is the “belief in efficacy of the advised action to reduce risk or seriousness of impact” to personal health and safety. Fourth, perceived barriers refers to the “belief about the tangible and psychological costs of the advised action” towards or against a particular health behavior. Fifth, cues to action are “the strategies to activate ‘readiness.’” Finally, self-efficacy is the “confidence in one’s ability to take action” (Champion & Skinner, 1999, p. 48).

Historically, women have been prevented from using their voices to express their personal feelings and tell their stories in a way befitting their actual experiences. The
The present study seeks to give survivors a platform through which to tell their stories surrounding IPV, and to generate insightful conversation regarding the current state of IPV public health campaigns. The Health Belief Model (HBM) was chosen for this study as a means of allowing women’s own voices to construct understanding of IPV within a framework that is meaningful to health scholars and campaign designers to not only inform, but to guide, message design in the future.

Overview

In chapter two, a review of literature offering contributions to the field is presented. More specifically, literature on IPV, mass media public health campaigns, and the health belief model is examined. Research questions are posed following the literature review. Chapter three details the methodology for the present study, including method selections, data collection, analysis, and interpretation procedures. Findings are presented in chapter four. Finally, chapter five examines the study’s implications, limitations, and recommendations for future research.
CHAPTER TWO
LITERATURE REVIEW

The present study builds on the existing literature surrounding intimate partner violence (IPV) and public health mass media campaigns, and provides a context for understanding survivors’ experiences with IPV in their own words. This study also positions survivors’ experiences within the Health Belief Model (HBM) framework in an effort to aid understanding of their reactions when viewing IPV campaign ads. As a result, the reactions of survivors of IPV to campaign ads may be used as a model to guide researchers and campaign designers as they create domestic violence prevention and intervention campaigns in the future. This chapter begins with a discussion of the seriousness of IPV in general, then provides a summary of the various forms of IPV, followed by the physical and psychological effects suffered by victims. The second half of the literature review discusses the HBM’s philosophical and theoretical foundations, which serves as a guide for designing the focus group interviews.

**Intimate Partner Violence**

Historically, IPV has been considered a private, family matter, and thus the courts were reluctant to interfere (Bettinger-Lopez et al., 2011). Until the mid-1800s it was entirely legal for men to beat their wives, and in 1871, Alabama became the first state to rescind the law (Congressional Digest, 2012). Prior to the 1970s, IPV shelters were almost unheard of, often leaving victims to fend for themselves if they decided to leave (Bettinger-Lopez et al., 2011). The *New York Times* undertook a review of articles written on wife abuse, and found zero articles on the subject in 1970 and 44 in 1977;
further, by 1978 the topic of wife abuse had become a separate category from that of assaults and murders (Dobash & Dobash, 1979). The 1970s was a turning point for IPV legislation, however, as individual states began authorizing judges to issue civil restraining orders (now referred to as orders of protection) (Bettinger-Lopez et al., 2011). Prior to this point, most of what we consider IPV today, was in fact, considered perfectly acceptable behavior exhibited by a husband towards his wife (Pleck, 1987). Despite the change in legislation concerning restraining orders, there still existed the question over whether a husband’s behavior towards his wife constituted grounds for divorce or was simply his way of correcting misbehavior (Dobash & Dobash, 1979). It was not until 1992 that the Supreme Court officially recognized the staggering breadth of IPV, reporting that 4 million women in the U.S. were assaulted by their intimate partner each year, and further that between one-fifth and one-third of all U.S. women would be the victim of IPV in their lifetime (Bettinger-Lopez et al., 2011). As a result of this, in 1994, Congress passed the Violence Against Women Act (VAWA), which funds investigations, research, and programs aimed at reducing the frequency of IPV in the U.S. (Bettinger-Lopez et al., 2011). VAWA was passed twenty years ago, yet IPV is still a pervasive public health issue in this country.

It was not until the latter half of the twentieth century that government agencies began to take notice of the effects of IPV on public health. In the mid-1980s, the CDC recognized the seriousness of partner abuse and began treating it like any other epidemic, collecting statistics to include in the epidemiology of homicide and suicide (“Epidemiology of Domestic Violence,” 1984). Since then, the CDC has continued to
characterize IPV as a national public health concern (Chrisler & Ferguson, 2006). As a result, the past three decades have seen an influx of health communication scholars researching IPV, its victims, its warning signs, and its widespread repercussions. Many of these studies focus solely on one aspect of IPV, most often physical violence (e.g., see meta-analyses by Archer, 2000, 2002). While the results of this research are as varied as the aspects of IPV being explored, several key facets provide foundational information for the field of IPV research.

**Forms of IPV**

According to the CDC (2014) there are four types of IPV: physical violence, sexual violence, threats, and psychological/emotional abuse. IPV varies greatly in frequency and severity of abuse, and occurs on a continuum that can range from one physical blow to severe beating, and even death (CDC, 2014). It is important to note that the various types of IPV do not typically occur alone, with many victims experiencing more than one at any given time (United States Department of Justice, USDOJ, 2011). Physical violence is defined as the intentional use of physical force potentially resulting in bodily harm, serious injury, a disability, and even death (CDC, 2014). The CDC (2014) lists several behaviors that constitute physical violence: scratching; pushing; shoving; throwing; grabbing; biting; choking; shaking; slapping; punching; burning; use of a weapon; and use of restraints or one’s body, size, or strength against another. IPV is the most common form of serious injury for women in the U.S., accounting for more injuries than car accidents, muggings, and rapes combined (Huth-Bocks, Levendosky, & Bogat, 2002). Prior research has shown a correlation between severe physical violence
and an increased impact on victims’ psychological health (Follingstad, Brenan, Hause, Polek, & Rutledge, 1991).

The CDC (2014) divides sexual violence into three categories: 1) the use of physical force to persuade a partner to engage in a sexual act against her will, whether or not the act is completed; 2) an attempted or completed sex act that involves a partner who is unable to comprehend the nature or condition of the act, unable to refuse participation, or unable to communicate unwillingness to engage in the act, e.g. due to illness, disability, influence of alcohol or drugs, or due to intimidation or pressure; and 3) abusive sexual contact. The National Coalition Against Domestic Violence (NCADV, 2007) reports that sexual assault occurs in roughly 40-45% of all battering relationships. In addition, the USDOJ (2009) reports that if physical violence is present in a romantic relationship, it is highly likely that sexual abuse is present as well. The likelihood of sexual violence increases with the severity of physical abuse (Gordon, 2000; Painter & Farrington, 1998). Additionally, sexual violence further compounds the health effects suffered by victims of IPV, as they often face chronic health issues in the future as a result of the violence (Foa & Riggs, 1994; Riggs, Kilpatrick, & Resnick, 1992).

Threats to an intimate partner can be in reference either to physical or sexual violence. Johnson (1995) found 97% of respondents had been threatened by an intimate partner, and 61% reported having been threatened quite often. In making a threat, one partner uses words, gestures, and/or weapons in order to communicate his intent to cause physical harm, injury, disability, or even death to the other partner (CDC, 2014). However, threats do not necessarily have to be directed at the partner. For example,
Johnson (1995) reports that abusers also involve the expression of anger towards an object (92%) or at children or pets (65%).

Psychological or emotional violence is a complex issue in part because it is not only a type of IPV in and of itself, but is oftentimes committed simultaneously with physical violence. This type of violence involves trauma to the victim caused by acts, threats of acts, or coercive tactics (CDC, 2014). Scholars have reported many victims find psychological and emotional violence more harmful and longer lasting than physical abuse (DeKeseredy & MacLeod, 1997; Fitzpatrick & Halliday, 1992). Psychological and emotional violence includes a long list of behaviors, including: humiliating the victim, controlling the victim’s actions, withholding information, making the victim feel diminished or embarrassed, isolating the victim from friends and family, and denying the victim access to money and/or other basic resources (CDC, 2014). Stalking is another type of IPV, but is often classified under psychological and emotional violence due to the perpetrator’s harassing or threatening behavior, including showing up at the victim’s home or place of business, making harassing phone calls, or vandalizing the victim’s property, that works to psychologically control a victim (Tjaden & Thoennes, 2008). Previous studies have connected emotional violence with higher rates of medical complaints (Stark & Flitcraft, 1988); depression and low self-esteem (Campbell, Kub, Belknap, & Templin, 1997; Campbell & Soeken, 1999; Zlotnick, Kohn, Peterson, & Pearlstein, 1998); psychosocial problems, and increased risk of rape, miscarriage, abortion, alcohol and drug abuse, attempted suicide (Stets & Straus, 1990); and overall emotional well-being, including posttraumatic stress disorder (PTSD) as a result of severe
stress (Campbell & Soeken, 1999). Further, the rates of suicide amongst victims of IPV has been found to be nearly 5 times higher than in non-battered women (Stark, 1984).

**Physical Effects of IPV**

The most common places of visible bodily injury to victims of IPV are to the face, neck, upper torso, breast and abdomen (Mullerman, Lenaghan, & Pakieser, 1996). Long after the physical manifestations of the violence have worn off, victims are often faced with further health effects as a result of stress and fear due to living with a violence partner. These physical effects include pain and discomfort from central nervous system (CNS) symptoms, such as headaches, back pain, fainting, and seizures (Leserman, Li, Drossman, & Hu, 1998; Cascardi, Langhinrichsen, & Vivian, 1992). Chronic fear and stress can also lead to gastrointestinal disorders and appetite loss (Leserman, Li, Drossman, & Hu, 1998; Coker, Smith, Bethea, King, & McKeown, 2000; McCauley, Kern, Kolodner, et al., 1995; Drossman, Talley, Leserman, Olden, & Barreiro, 1995), viral infections, such as the common cold and the flu (Leserman, Li, Drossman, & Hu, 1998; Kerouac, Taggart, Lescop, & Fortin, 1986; Letourneau, Holmes, & Chasendunn-Roark, 1999), and cardiac issues, such as hypertension and chest pain (Coker, Smith, Bethea, King, & McKeown, 2000; Letourneau, Holmes, & Chasendunn-Roark, 1999; Schei & Bakketoeig, 1989; Koss & Heslet, 1992). In addition to the obvious cuts and bruises endured by victims of IPV, there are often less-seen, yet serious health consequences. Previous studies have shown that nearly half of all abused women have reported forced sex at least once with their intimate partner (Campbell & Soeken, 1999). This can lead to an increased risk of sexually transmitted diseases, such as HIV, and an
increase in gynecological issues, such as vaginal bleeding or infection, fibroids, pelvic pain, and urinary tract infections (Leserman, Li, Drossman, & Hu, 1998; McCauley, Kern, Kolodner, et al., 1995; Letourneau, Holmes, & Chasendunn-Roark, 1999; Schei & Bakketeig, 1989; Schei, 1991; Eby, Campbell, Sullivan, & Davidson, 1995; Plichta & Abraham, 1996). Campbell et al. (2000) note that women forced into sex by an intimate partner have less control over their reproductive functions, which can result in an unwanted pregnancy, and lead to health consequences for both mother and child.

**Psychological Effects of IPV**

As previously noted, psychological effects of IPV can often have far devastating consequences than the physical blow (Kirkwood, 1993). Victims of IPV seek professional healthcare for mental health effects just as frequently as they do for physical effects (Campbell & Lewandowski, 1997). While the cuts and bruises eventually fade, research has shown that the emotional effects persist far longer (Campbell, n.d.). The psychological ramifications experienced by survivors of IPV range from low self-esteem to clinically diagnosed Post Traumatic Stress Disorder (PTSD) (Johnson, 2008). PTSD has long been considered as a sequelae of IPV, and previous research has found a higher prevalence of PTSD in abused women than in non-abused women (Golding, 1999; Silva, McFarlane, Soeken, Parker, & Reel, 1997). While some victims may have pre-existing chronic depression that is exacerbated by the stress of their situation, research has shown that first onsets of depression can be caused by acts of partner violence (Campbell & Soeken, 1999; Silva, McFarlane, Soeken, Parker, & Reel 1997). Studies have demonstrated that depression is the most commonly diagnosed mental health effect
resulting from partner violence (Hamberger, Saunders, & Hovey, 1993). Other mental health effects linked to IPV include anxiety, insomnia, and social dysfunctions (Ratner, 1993). Scholars have found a connection between partner violence and abuse of alcohol and drugs (Ratner, 1993; McCauley, Kern, Kolodner, et al., 1995; Golding, 1999; Amaro, Fried, Cabral, et al., 1990; Martin, Kilgallen, Dee, Dawson, & Campbell, 1998) by women who are looking to cope with their situation (Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997) or escape from their reality completely (Campbell, 2002). Research has also connected IPV with an increase in suicidal tendencies amongst victims (Counts, D. A., 1987; Bergman & Brismar, 1991; Golding, 1999).

As a public health concern, IPV and its effects are studied by both the public and nonprofit sectors. In doing so, these agencies look to identify ways to combat the onset of IPV, and ways to assuage its aftereffects. Effective communication campaigns designed to educate the public about IPV are necessary to reduce the number of incidents, yet there is very little research in this area. In order to effectively design mass media public health campaigns aimed at IPV, there must first be an understanding of the very basics of public health campaign design.

**Public Health Campaign Design**

Rice and Atkin (2009) define public communications campaigns as (1) purposeful attempts (2) to inform, persuade, or otherwise motivate behavior changes (3) in a well-defined and large audience, (4) for noncommercial benefits to the individual and/or society at large, (5) usually within a specified period of time, (6) using organized communication activities that involve mass media, and (7) often accompanied by
interpersonal support (adapted and expanded from Rogers & Storey, 1987). Rogers and Storey (1987) assert that the essence of a health communication campaign involves a systematic approach to achieving the specified outcome within a large population. Despite the long history of public health campaigns, research has not always supported their actual effects. Among other complaints, health campaigns have been faulted for attempting to change people’s behavior without changing their circumstances (Green, 1996) and for falsely assuming that knowledge both reaches and affects all people in the same way (Brown & Walsh-Childers, 1994). du Pré (2014), explains that health campaigns may indeed be successful at raising awareness of a given health issue, but will ultimately fail unless the recommended behaviors are both compatible with people’s existing beliefs and are supported in their social networks. Furthermore, campaign designers must know their intended audience and understand how that audience might benefit from the recommended health behavior, and consequently, whether they would find that behavior change difficult or outright unacceptable (du Pré, 2014). In order to design and implement a successful campaign, designers need to perform a situational analysis, develop a strategic plan, use principles of effective media campaigns to create and place health messages, and finally must rely on the data at each phase of this process (Rogers & Storey, 1987).

**Formative research.** The first step in campaign design is formative research, which as its name suggests, is conducted prior to actual message design. Formative research, or formative evaluation, is defined as the “systematic incorporation of feedback about one or more components of a planned activity before communication with a target
audience” (Meyer & Dearing, 1996, p. 46). Formative research is conducted in order to shape the final product (Witte, Meyer, & Martell, 2001). It is during this phase that researches identify a target audience, determine demographic variables of that audience, and finally, identify prior experiences, beliefs, and perceptions of the audience surrounding the health threat and the recommended preventative behavior (Witte, Meyer, & Martell, 2001). This type of formative evaluation is referred to as preproduction research, because it occurs before any campaign message has been tested, and is used only to gauge the target audience’s current perspectives on the given health behavior and their preferred channels of communication (Atkin & Freimuth, 1989). Identifying a target audience is merely an initial step in determining the particular segment of the population on which the campaign will focus. During formative research, Salmon and Atkin (2003) recommend the design team identify focal segments of the population whose health behaviors are in need of change, and then identify those behaviors that the campaign ultimately intends to change. After this point, campaign designers can begin to narrow down their target audience population into more manageable segments of intended audiences.

**Intended audiences.** Du Pré (2014) says designers must know their audience and strive to design campaigns that exclusively suit that audience. Undertaking audience analysis before setting campaign goals and desired outcomes, allows researchers to collect necessary data as to people’s behaviors and preferences, trusted sources, main concerns, and more (Ledlow, Johnson, & Hakoyama, 2008), thereby enabling campaign designers to effectively design messages that both appeal to the audience’s current
identity and sense of self, as well as to predict health promoting behaviors to which that audience may subscribe. Campaign designers who engage in audience-centered analysis send the message “that health messages are designed primarily to respond to the needs and situation of the target audience, rather than to the needs and situation of the message designers or sponsoring organization” (Maibach & Parrott, 1995, p. 167). In order to successfully designate a target audience, Rice & Atkin (2009) advocate for the use of targeted audience segmentation, that is, identifying sub-audiences. It is nearly impossible for one campaign to effectively reach all possible audience members, and therefore, campaign designers need to narrow down their field of focus for optimal results. In this way, designers are able to separate out those audience members who are at the greatest need for the campaign message, who are more receptive to that message, and furthermore allow designers to create messages aimed solely at that audience’s preferences, media usage, and abilities (Rice & Atkin, 2009). Salmon and Atkin (2009) reveal two prime advantages to audience segmentation. First, campaign designers can maximize the efficiency of the campaign messages if they first determine that segment of the audience who is most in need of the health message, and who would be most receptive to hearing that message. Second, overall campaign effectiveness can be maximized if all areas of the campaign, message content, form, and style, are tailored specifically to the predispositions and abilities of a particular audience segment (Atkin & Freimuth, 2001; Dervin & Frenette, 2001). A prime example of a campaign using targeted audience segmentation is one that focused on African American women and the issue of breast cancer. Campaign designers set out to determine where these women received and shared
the most information, and found that place to be the beauty salon (Forte, 1995). Armed
with that information, researches partnered with Los Angeles-based beauty salons to
show their campaign video promoting breast health and mammography, followed by free
mammograms. Of the campaign’s success, Deidre Forte says, “by showing the video
where African American women already exchange information and socialize, they are
more likely to understand and accept the benefit of mammography” (du Pré, 2014, p.
345). Typically, campaign designers zero in on three types of audiences (Rice & Atkin,
2009). Focal segments are those audiences grouped by levels of risk or illness, readiness,
and income and education. The second type, interpersonal influencers are those people
who can help to set the public agenda where the campaign’s message is concerned, and
include key opinion leaders, media advocates, and role models. Finally, societal
policymakers are audiences who have the ability to affect the legal, political and resource
aspects of the campaigns through regulation of media messages, safety standards, and
federal allocation of funds. Once the intended audience has been designated, researchers
can begin the process of message design.

**Message design.** The defining element in any public health campaign is the
content, form, and style of its health messages. Message design includes “strategic
selection of substantive material, mechanical construction of message components, and
creative execution of stylistic features” (Salmon & Atkin, 2003). When dealing with
persuasive health messages, as a large percentage of health campaigns are intended to
change a particular health behavior, incentives are of utmost concern to campaign
designers. Persuasive health campaigns are designed either to promote or attack a
particular health behavior, and in doing so are often accompanied by either positive or negative incentive appeals (Salmon & Atkin, 2003). Salmon and Atkin (2003) suggest several qualities that make campaign messages more effective. First, the audience must deem the message content and its source credible. Next, the audience must find the message style and contents to by engaging. Third, campaign messages must appeal to the audience’s sense of self, by including information relevant to that audience so they feel the messages relate to them personally. Finally, messages should be designed such that they are easy for the audience to understand.

Salmon and Atkin (2003) identify several incentive appeals found within campaign messages, and how those appeals affect the influence health campaigns have on the audience’s eventual behavior. A common approach in health campaigns is to use fear appeal messages, in an effort to promote health behavior change through the threat of harmful health outcomes. Previous campaigns have faced negative repercussions in their use of fear appeal messages, as too little fear holds little persuasive value, and too much fear can leave the audience unwilling or unable to process the information (Murray-Johnson & Witte, 2003). In a campaign designed to increase condom use, Sheer (1995) found this statement to be ineffective, “I have a lot of feelings for you and I don’t want anything to happen to you. So, let’s use a condom.” This statement did not create enough fear within its target audience, and was therefore ineffective. Salmon and Atkin (2003) suggest campaigns increase their use of positive appeal messages. In doing so, campaigns can relay the potential positive outcomes of performing the prescribed health behavior change. Positive social incentives include being cool, earning approval and respect,
forming friendships, building trust, and being a good role model (Salmon & Atkin, 2003). Potential psychological incentives include, gaining control over one’s life, achieving a positive self-image, attaining goals, feeling secure, and acting intelligently (Salmon & Atkin, 2003). Once the messages have been designed, researchers must select channels through which to disseminate them.

**Channel selection.** Traditionally, public health campaigns are disseminated to the public using television, radio, newspapers, and printed materials, especially broadcast spots, press releases and pamphlets (Salmon & Atkin, 2003). Atkin (1994) recommends weighing various channel options by reach (how much of the community is exposed to the message), specialization (how well the campaign can target specific subgroups), intrusiveness (ability of the campaign to overcome selectivity and to command audience attention), safeness (avoiding the risk of boomerang effects or audience irritation), participation (active audience involvement while processing the stimuli), meaning modalities (multitude of senses employed as meaning is conveyed), personalization (source-receiver interaction), decodability (effort required for audience to process the message), depth (channel’s capacity to convey detailed and complex content), credibility (believability of the message), agenda-setting (ability of selected channel to raise salient priority of the issue), accessibility (ease with which messages can be placed in the selected channel), economy (cost of producing and distributing the messages), and efficiency (simplicity of arranging for the messages to be produced and distributed). In order to determine the most effective channels for the intended audience, designers
should focus on the channel usage patterns of the audience and the nature of the message trying to be conveyed (Salmon & Atkin, 2003).

**Process evaluation.** du Pré (2014) recommends campaign designers establish goals and to determine ways of regularly measuring campaign success. This sentiment is echoed by Salmon & Atkin (2003), who say that designers must rely on research inputs at each critical phase of the research process in order to let the data speak and guide the next phase in the study. Process evaluation involves monitoring and collecting data to aid in the fidelity and implementation of the campaign (Valente, 2001). The Minnesota Heart Health Program is one of the most extensive health campaigns in U.S. history, having spanned 13 years (1980-1993) and including more than half a million participants (Luepker et al., 1994). du Pré (2014) was particularly impressed with the campaign’s dedication to monitoring health outcomes of participants throughout the entire length of the study, and in addition, the significant results provided when researchers compared participants’ outcomes with those who were never exposed to campaign messages. du Pré (2014) advocates for the recruitment of social support networks for a particular new health behavior because the greater the social support, the higher the likelihood that people will stay true to the newly adopted behavior. The 90-Second Intervention exemplifies this component in part because of their campaign design principle that patients would be more likely to adopt behaviors aimed at lowering blood pressure if they had support outside of the medical field encouraging them to eat right, exercise, and take their medication (Fishman, 1995).
**Outcome evaluation.** The past several decades have seen an increase in scholars evaluating the effectiveness of public health campaigns (Atkin, 1981, 2001; Backer, Rogers, & Sopory; DeJong & Winston, 1990; Snyder, 2001). Evidence has shown that conventional public health campaigns have very little direct effect on health behaviors (Salmon & Atkin, 2003). Snyder (2001) found that health effects are stronger for those campaigns seeking to get audiences to adopt a new behavior (an average 12% of audiences adopt new practices, such as exercise, condom use, and dental care) rather than the cessation of a current behavior (an average 5% cease habits, such as smoking, binge drinking, and risky sex). Rice & Atkin (2009) conclude that outcome evaluation involves answering questions related to six campaign aspects: (1) the audience, its size and characteristics; (2) how well campaign components were implemented (i.e. the dissemination of messages and/or services); (3) effectiveness (campaign’s influence on attitudes, behaviors, and health conditions); (4) the campaign’s impacts on larger audiences (i.e. intended audience’s family and friends and local, state, and federal government agencies); (5) cost (i.e. total expenditures and overall cost-effectiveness); and (6) causal processes (determining the reasons for why positive/negative effects occurred) (adapted from Flay & Cook, 1989).

**Future Direction of Campaign Design**

Mass media public health campaigns continue to prove one of the most well used avenues for communicating the need for behavior change amongst large audiences. While there have indeed been numerous effective public health campaigns over the years, research has shown a majority of conventional public health campaigns to be ineffective
at behavior change (Salmon & Atkin, 2003). In order to increase the effectiveness of these campaigns, scholars have suggested several areas that need improvement.

Murray-Johnson & Witte (2009) note that numerous studies have evaluated the effects of individual variables of public health campaigns, but have largely failed to evaluate multiple effects together. They call for scholars to examine both the intended and unintended effects of public health campaigns within one study, so as to determine the interplay between these effects in order to hopefully eliminate negative effects in future campaigns. Health-related behaviors are derived from a multitude of factors, thus suggesting the need for health research to examine factors such as social and environmental contexts, values, the political environment, policies, and mandates on those behaviors (Murray-Johnson & Witte, 2009). There exists the need for future scholarship to determine the effects of variables such as perceived susceptibility, severity, self-efficacy, response efficacy, outcome expectations, barriers, benefits, attitudes, and social norms on the outcome of audience attitudes, intentions, and behavior (Murray-Johnson & Witte, 2009).

The channels through which campaign designers deliver health messages is of utmost importance to the overall success of the campaigns. There is a renewed call, however, for an evaluation into how messages are currently being delivered in order to make that process more effective (Murray-Johnson & Witte, 2009). Scholars have a keen understanding of the traditional channel forms, such as the telephone, television, and newspaper, but in an age of ever-increasing technological advances, there exists a need to expand beyond these traditional channels. For example, Salmon and Atkin (2003)
advocate for the use of public relations techniques in order to successfully reach a campaign’s intended audience. As the health of mind and body has become an increasingly popular topic, Salmon and Atkin (2003) suggest campaigns take advantage of the interests of such channels as news magazines, television newscasts, specialty magazines, cable channels, and daytime television talk shows. Placing campaign messages in the media can have several advantages over placing them in conventional, prepackaged stimuli such as public service announcements, pamphlets, and Web pages. Research has shown that messages found in the informational media tend to carry more credibility than packaged messages that use a general advertising format, and credibility is one of the strongest indicators of a person’s willingness to adopt the recommended health behavior (Salmon & Atkin, 2003). Further, strategically placing health messages in the news media can increase the likelihood that the intended audience sees the health threat as more urgent and significant than previously thought (Salmon & Atkin, 2003). In addition to the channels through which messages are delivered, designers need to focus in on the noncontent variables of messages and how those variables may be interpreted differently depending on the channel through which the message is disseminated. These variables of interpersonal communication include vocal tone, pace, and nonverbal elements related to the health behavior (Murray-Johnson & Witte, 2009). One study posits that the verbal content of messages accounts for only 7% of the meaning audiences extract from it (Mehrabian, 1971). Based on the results of this study, health campaign designers have considerable ways to go in their study and design of campaigns, as their
focus up to now has been predominantly on message content variables, with this research demonstrating a need for focus to be placed on message design variables instead.

Little is known about how campaign messages trigger cognitive and emotional responses in their intended audiences. Murray-Johnson & Witte (2009) call for an increase in studies that examine how audience responses to a threat differ than their response to benefits, and consequently how those responses affect message processing and persuasion. Extensive research has been carried out on campaign messages in laboratory-based settings, however, there is mounting need for information as to how these message content and design variables operate in real-life settings (Murray-Johnson & Witte, 2009). For example, Kline and Mattson (2000) conducted an analysis of breast self-exam pamphlets and found messages focused on self-efficacy lacked a quality that would have an affect on attitudes, intentions, and most importantly behavior change. Based on these results, researchers concluded that this lack of quality would impede the audience’s intention to perform the recommended health behavior, but there is no real evidence to support this.

Stigmatized Issues in Public Health Campaigns

Mass media public health campaigns have seen numerous changes since their inception in the early- to mid-1900s. Rogers and Storey (1987) charted the history of mass media campaigns, and found that the 1940s and 1950s were an era of minimal effects, whereby many of the large-scale campaigns failed to accomplish their goals, and scholars undertook efforts to determine the cause. The 1960s and 1970s can be described as the campaign can succeed era, which saw considerable campaign success, and with it,
a new optimism for the field of public health campaigns. It was during this time that scholars pointed to ineffective campaigns, rather than intended audiences, for the failure of public health campaigns in the past, and consequently formalized strategies for effective campaign design (Rogers, 1996). The final decade under review for the meta-analysis, the 1980s and 1990s, was described as an era of moderate effects. During this time, campaign designers became more comfortable with how campaigns worked, what made them effective, and what potential outcomes may arise. Because of this, campaigns designed and implemented during this time began to see moderate success rates. Noar (2007) describes campaigns at the beginning of the twenty-first century as belonging to the era of conditional effects, whereby no new principles of campaign design have been formulated, but scholars have managed to effectively and creatively utilize campaign strategies from previous decades.

Public health campaigns have long since targeted stigmatized health issues such as sexually transmitted diseases, like HIV/AIDS and HPV, and scholars have endeavored to study how those campaigns shape the intended audience’s response to the health threat. Fear appeal messages are a fundamental component in health risk communication, showing intended audiences the consequences they will experience if they do not stop risky behavior or start preventative health behavior (Witte, 1994). Fear appeals are the most widely used message tactic in public health campaigns that seek to elicit behavior change (Freimuth, Hammond, Edgar, & Monahan, 1990). The success of fear appeal messages can change based on the stage of change experienced by the intended audience (Cho & Salmon, 2006). If they are effective, fear appeals will aid an individual by
strengthening their intentions to engage in preventative health behavior (Maibach & Cotton, 1995). However, if not effective, fear appeal messages will distract audiences and prevent them from adopting the recommended behavior (Maibach & Cotton, 1995). Information on fear appeal messages is important to the discussion of stigmatized health issues in mass media campaigns, as a large percentage of these campaigns utilize fear appeals to change health behavior. Essentially, fear appeals are successful if that perceive threat is successful at motivating action within the individual, and in turn, if the individual’s perceived sense of self-efficacy works to determine the nature of the action to be taken. While so many campaigns make use of these fear appeals, little research has been dedicated to examining the intended and unintended effects these fear appeals create.

Green and Witte (2006) undertook a research study to determine if fear appeals in mass media campaigns have contributed to the decline in HIV prevalence. The researchers set out to determine if fear appeal components found in public health campaigns in Uganda during the height of the AIDS crisis contributed to the overwhelming reduction in the number of HIV cases there. Fear appeals were the strongest during the early part of the national response to the crisis (1986-1991), after which point there appeared to be a major decline in HIV incidences (Low-Beer, 2002), further leading to a 66% decline in the prevalence of HIV in Uganda (Shelton et al., 2004). As the HIV crisis in Uganda declined, those campaigns developed by the African government were replaced by softer campaigns designed by American AIDS experts. Recent data has suggested that the incidence of HIV is again on the rise in Uganda.
This study demonstrates that not only is there a need for fear appeal messages in public health campaigns, but that a delicate balance must be struck between fear appeals that evoke negative and unintended reactions, and those messages that do not elicit a reaction at all.

Similar results were found in a study investigating threats in fear appeal messages regarding the HPV vaccine (Carcioppolo et al., 2013). Few studies have explored the connection between threat and self-efficacy in campaign messages, despite general consensus amongst communication models that the two are considered principle theoretical components to any health message, including the health belief model (Rosenstock, Strecher, & Becker, 1988). Carcioppolo et al. (2013) sought to determine the ways differing threat-to-efficacy rations could impact intended audiences. Messages can be manipulated to impart increased levels of threat, self-efficacy, or equal levels of both. A balance must be found between the two in order to accomplish health communication’s goals of emphasizing the threat of the particular health concern and generating enough self-efficacy for the audience to act on that concern (Carcioppolo et al., 2013). In their study, Carcioppolo and colleagues (2013) found that messages conveying a low sense of threat did not influence audience intentions as much as those messages conveying a standard, or median, level of threat. The low threat messages elicited less fear and susceptibility from the audience than did the standard message. Further, those messages conveying a low sense of self-efficacy likewise yielded lower intentions to take the recommended preventative health action regarding HPV. Overall, Carcioppolo et al.’s (2013) study found varying effects of threat-to-efficacy ratios on
college women’s intentions regarding HPV vaccination, it did find evidence suggesting future campaigns should focus in more on the connection between HPV and genital warts. This conclusion can be broadly applied to other areas of health communication campaigns, particularly those involving other stigmatized issues, such as IPV.

**IPV Public Health Campaigns**

Despite concerted efforts by scholars to research the broad subject of IPV, very little research has examined victim’s experiences with IPV and how those experiences affect their response to prevention and intervention campaign ads. Communication scholars have identified several challenges facing the design of a campaign targeting IPV: (1) identifying the appropriate target group (victim, abuser, or bystander) and determining the desired outcome of the campaign; (2) deciding whether the campaign will target the change of individual behavior or adopting new social norms; and (3) designing effective campaign messages that will not incur further psychological harm on victims of the violence (Commonwealth Fund Commission on Women’s Health, 1998). Heise (1998) concludes that the most effective campaign strategy for IPV prevention and intervention is the design of messages that not only raise consciousness over the issue but also move the general public to a disapproval over the act of partner violence. In the past 15 years, a handful of studies have set out to accomplish Heise’s recommendations, with mixed results.

In one such study, Keller and Otjen (2007) worked with college students to design IPV campaign ads to increase the perceived threat of abuse. They endeavored to see the public consider IPV “a severe community problem” (p. 53). Participants “included
potential or current victims of abuse and those who are not directly involved in abuse but might have friends or relatives who are victims” (Keller & Otjen, 2007, p. 237). The survey results proved to be disappointing, as Keller et al. (2010) noted in their follow-up article. Researchers identified several missteps related to the process of creating a campaign. One of the most important aspects overlooked were the challenges faced by health communicators, who are tasked with successfully conveying the health risk before trying to change health behavior (Keller et al., 2010; Witte, Meyer, & Martell, 2001). In analyzing their own campaign, Keller et al. (2010) decided to examine “the overall effectiveness of the campaign using components of the HBM as an analytical tool” (p. 53). The results of this analysis aid in shaping our understanding of IPV campaigns, their design process, and their overall effectiveness.

Keller et al. (2010) identify five specific unintended effects of health communication campaigns, including two that affected their Open Your Eyes (2007) campaign. The first unintended effect, unintended or excluded audiences, asserts that failure to consider neglected or accidental audiences could prove detrimental to the overall success of the campaign. The second unintended effect, boomerang effects, is arguably one of the more serious results of poorly designed campaigns. Witte, Meyer, and Martell (2001) “suggest that when a person’s perceived threat begins to exceed their perceived sense of self-efficacy, the person will focus on how frightened he or she feels and try to eliminate fear through denial, defense-avoidance, or reactance” (p. 27). In an IPV campaign, these effects could prove deadly. A qualitative study that asked survivors of IPV to respond to campaign ads found that many women felt embarrassed and
ashamed, and consequently refused to admit ever having been in that type of situation (West, 2013). One participant said of women depicted in the ads, “They look victimized. Down-trodden and pathetic. I wouldn’t want to say that’s me even if it was—which it wasn’t.” The identification of this unintended effect is supported by a Harvard School of Public Health study, which “recommends that public service messages designed to deter certain behaviors should avoid message executions that evoke negative emotions” (Block & Keller, 1995, pp. 192-193). The study further states, “public service campaigns using negative language to frame their messages are less effective than public service messages using positive frames” (p. 193). A large number of IPV campaigns focus on the negative physical and psychological effects of violence, not on the positive effects of facing a future free from abuse.

The third unintended effect is culpability. A common misconception amongst campaign designers is that “most health messages are based on the presumption that individuals have the potential to change their behaviors” (Keller et al., 2010, p. 54). Campaign designers need “to be sure that no consumer group receiving the message is unintentionally harmed” (West, 2013, p. 197). For women unable to leave their current situation, exposure to campaign ads that result in increased guilt over their “poor health behavior,” only lead to further emotional distress (West, 2013, p. 54). Keller and Otjen’s *Open Your Eyes* campaign fell victim to the fourth unintended effect, social reproduction. Social reproduction involves the reinforcement of existing social stigmas. One prominent social stigma related to IPV is the belief that trying to leave an abusive relationship will result in murder. This social stigma was reinforced by Keller and Otjen’s (2007)
campaign ad depicting the feet of a murdered woman with the caption “Mommy, Wake Up” and the statistic that “47% of women murdered in Montana last year were killed by their husbands or boyfriends” (p. 239). The fifth, and final, unintended effect of health campaigns is social norming. Victims of IPV often feel isolation and shame, which is further compounded by the realization that they are deviating from societal norms. Public health campaigns, particularly those addressing IPV, often contribute to these feelings of isolation and shame among survivors. While Keller et al. (2010) determined design flaws in their own campaign messages, they pinpointed those flaws themselves, without ever having consulted their campaign’s intended audience: survivors of IPV.

Lederman and Stewart (2003) undertook a research study to assemble focus groups of college-aged students in order to test their reactions to messages in consideration for inclusion in an IPV campaign. The idea for the mass media campaign evolved from research suggesting rising numbers of incidents amongst college students (Jacobs & Poole, 1999; Miller & Bukva, 2001). The researchers followed the recommended strategy of designing an educational campaign that would present information to the intended audience in such a way as to change their knowledge, attitudes, beliefs, and behavior regarding the particular health issue (Salmon & Murray-Johnson, 2000). The overall goal of the research study was to conduct focus groups that would identify messages deemed effective at increasing college students’ awareness of IPV and in motivating those students to actively seek intervention programs on campus. In order to accomplish their goal, Lederman and Stewart (2003) assessed language use, message placement, and media selection within each campaign message. A significant
focusing on the terminology used when describing acts of violence. Most participants did not identify with the term “domestic violence,” saying it evoked images of an older, married man hitting his wife, and thus led them to disregard the campaign message as not relevant to their life (Lederman & Stewart, 2003). In addition, participants did not identify with the slogans used in campaign messages, citing them as out of tune with the “voice” of college students. Lederman and Stewart’s (2003) research study draws attention to the importance of understanding a campaign’s intended audience, its language use, and its beliefs in order to design messages that will promote health behavior change.

There is only one known study to date to bring survivors of IPV together in focus groups to discuss campaign ads in an effort to understand how their experiences with abuse shape their perceptions (West, 2013). In light of September 11th, 2001, West (2013) identified a need for the media to properly educate the public about an act of terrorism that occurs behind closed doors every day: intimate partner violence. Further, West endeavored to design a research study whose results would aid in prevented negative health consequences as a result of poorly defined public health campaigns in the future. West (2013) hypothesized that victims of IPV “would report experiencing negative emotional effects, particularly fear and shame, when viewing” (p. 198) campaign material, and assembled 10 focus groups of four to six women each at women’s shelters in order to test that hypothesis. In the study, participants were asked to react to current IPV print and radio advertisements. Results revealed six emotions expressed by participants: shame, embarrassment, lack of empowerment, fear, anger, and hopelessness.
The negative emotions evoked further highlight “the consequences of not considering the potential negative effects of the public service advertising” on the population most vulnerable (West, 2013, p. 198). Survivors identified negative emotions evoked by the campaigns, and pointed out inaccuracies in the depictions of violence. One response, coded as shame, “you don’t always see those marks,” makes clear that not all women are physically beaten, yet still suffer all the same. Another woman said of the ads, “I don’t like looking at that and hearing it because it brings back that feeling of absolute terror.” Another participant echoed the sentiment, “I can’t see beyond the horrible scenario represented here. It really presents a hopeless picture,” before verbalizing her desire for ads that, “show me how much better things can be.” West’s research demonstrates that survivors reject those ads that make them feel hopeless, and highlights the need for further research into how survivors’ perceptions of campaign ads are influenced by their own experiences with IPV.

While the past decade has seen an increase in the number of studies examining mass media public health campaigns aimed at the prevention and intervention of IPV, there remains much work to be done in designing, implementing, and analyzing these campaigns. Keller et al. (2010) and Lederman and Stewart’s (2003) studies failed in several critical aspects of Salmon and Atkin’s (2003) recommendations for designing a successful campaign. The area of most concern is that of formative research, because the entire campaign, and its success, rests on this background information. The common link in the failure of aspects of these campaigns appears to be researchers’ neglect in consulting with members of their intended audience before messages were designed.
West’s (2013) focus group interviews with victims of IPV highlights the importance of consulting them before IPV campaign messages are designed. Their reactions demonstrate a clear disconnect between what campaign designers think their audience wants to hear, and what messages actually resonate with that audience.

**Health Belief Model**

The HBM (Janz & Becker, 1984; Rosenstock, 1974) is one of the most widely used models in health communication research. Previous studies have used the HBM to guide research on campaigns targeting the use of a bicycle helmet (Witte, Stokols, Ituarte, & Schneider, 1993), vaccinations for infectious disease (Eisen, Zellman, & McAlister, 1985), and risky sexual practices (Vanlandingham, Suprasert, Grandjean, & Sittitrai, 1995). The model was originally developed as a framework for promoting preventative health behaviors (such as immunizations) by a group of social psychologists in the 1950s (Janz & Becker, 1984).

The HBM suggests five factors that influence preventative health behaviors: (1) perceived barriers to taking preventative health action; (2) perceived benefits to taking preventative health action; (3) perceived susceptibility to the health threat; (4) perceived severity of the health threat; and (5) cues to action. The model suggests that people weigh the potential benefits of taking a recommended health action against the potential barriers (psychological, physical, and financial costs) (Witte, Meyer, & Martell, 2001). Rosenstock (1966) claims that people will be more likely to adopt the recommended health behavior if they feel susceptible to the negative health threat. For example, previous research has shown women are less likely to go in for a mammogram if they do
not feel susceptible to breast cancer (Hyman, Baker, Ephraim, Moadel, & Philip, 1994). Further, Rosenstock’s (1966) model predicts that the stronger the perception of the severity of the health threat, the more motivated a person will be to avoid the negative outcome. Hyman et al. (1994) found that women are more likely to get a mammogram if they believe breast cancer has a high risk of death when left untreated. In order to partake in the recommended health behavior, an individual must believe that behavior will bring positive health benefits. In the case of breast cancer, women must believe that mammograms will detect cancer, or they will not schedule one (Hyman et al., 1994).

Finally, Rosenstock (1966) argues that if an individual perceives strong barriers to taking the preventative health response, they are unlikely to do so. Hyman et al. (1994) found that some women refused mammograms because they were painful even though they believed the tests to accurately diagnose breast cancer. Cues to taking recommended preventative action can come in the form of external cues, such as a mass media campaign, or internal cues, such as a change in bodily state (Carpenter, 2010). There exists great need for scholars to research cues to action, as it remains the most underdeveloped and rarely measured or researched component of the model (Janz & Becker, 1984; Rosenstock, 1974; Zimmerman & Vernberg, 1994).

In addition to providing to providing us with a useful framework for assessing public health campaigns, the HBM also reminds us to continuously check the beliefs and preferences of our intended audience (du Pré, 2014). Previous research on smoking campaigns found that 34% of the general public still do not know that cigarette smoking can cause or exacerbate oral cancer; and additionally, 35% of the general public are
unaware that cigarette smoking increases the risk for a stroke (Krosnick, Chang, Sherman, Chassin, & Presson, 2006). These findings further support the need for effective formative research, and lays the groundwork for using the HBM from the beginning as a tool to design public health campaigns.

Research on women’s health issues and the HBM are numerous, with more popular topics covering mammography (Champion, 1992, 1998; Rakowski et al., 1992; Rakowski, Rimer, & Bryant, 1993; Slenger & Grant, 1989; Thomas, Fox, Leake & Roetzheim, 1996; Champion & Huster, 1995; King et al., 1993; Rimer et al., 1992; Champion & Skinner, 1999; Skinner, Champion, Gonin, & Hanna, 1997), cervical cancer screening (Hennig & Knowles, 1990; Hill, Gardner, & Rassaby, 1985; Stanley, Thomas, King, & Richardson, 2014), and sexually transmitted diseases (Hiltabiddle, 1996; Falck, Siegal, Wang, & Carlson, 1995; Staggers, Brann, & Maki, 2012; Giuliano, et al., 2011; Burak, & Myer, 1997).

As of this writing, only one study has used the HBM to measure the effects of an IPV campaign (Keller, Wilkinson, & Otjen, 2010). In examining the unintended effects of an IPV campaign, this study suggested that campaigns often reinforce existing stigmas related to IPV. Specifically, the study presented three hypotheses: (1) campaign exposure increased awareness of domestic violence services; (2) campaign exposure increased perceived severity of domestic violence; and (3) campaign exposure increased beliefs about the response efficacy of domestic violence services (Keller et al., 2010, p. 56). The measurement of self-efficacy was not part of the original HBM, but was introduced by Rosenstock et al. (1988) after their review found self-efficacy was important “in helping
to account for initiation and maintenance of behavioral change” (p. 179). Keller et al.’s (2010) research found, “88% of the respondents agreed with the statement ‘Physical, sexual, emotional, spiritual, and economic harassment are all forms’” of IPV (p. 59). One of the main issues survivors have raised with IPV campaigns is their depiction of violence as largely physical. While Keller et al. (2010) used the HBM for their study; they did not test the component known as perceived susceptibility. In their section for future research, they suggest a study that incorporates all aspects of the HBM, which will result in a better understanding of why people react the way they do to IPV campaigns. This study demonstrates the advantages of using the HBM to analyze IPV campaigns. However, the fact that Keller et al. (2010) have conducted the only study to date that pairs the HBM with IPV research reveals the gaping need for scholars to devote more time in this area.

In addition to using the HBM to analyze existing mass media public health campaigns, researchers can use the components of the HBM during the design process to design campaign messages that effectively reach their intended audience. Murray-Johnson and Witte (2009) suggest several content variables to consider when designing campaign messages. First, researchers should consider cues to action. This stimuli was originally developed as part of the HBM (Rosenstock, 1974b, 1974c), but has been used in the design process of health campaigns targeting issues such as adolescent health (Weiler, 1997), AIDS/HIV (Mattson, 1999), drugs and tobacco prevention (Borland, 1997; Hahn, Simpson, & Kidd, 1996; Hawkins & Hane, 2000), and mammography (Fox, Stein, Gonzalez, Farrenkopf, & Dellinger, 1998). Cues to action are essential to campaign
design because they are those content variables that prompt audiences to pay attention to the content of the message, and consequently, these cues can trigger the necessary motivation for the audience to assess the available resources when deciding whether or not to take the recommended preventative health behavior (Murray-Johnson & Witte, 2009). Next, designers should consider the component of perceived severity when creating campaign messages. Perceived severity of a particular health threat relates to how little or how much harm the audience feels is associated with the health threat. Successful campaigns will convey the message of moderate perceived severity, imparting to their audience the message that negative consequences will result if preventative behavior is not taken, and in addition, those consequences will be devastating (Murray-Johnson & Witte, 2009). In order to drive home the importance of using the component of perceived severity when designing messages, Murray-Johnson and Witte (2009) highlight a failed AIDS campaign used in the early 1990s. Perloff and Ray (1991) analyzed 25 AIDS brochures targeting intravenous drug users and their partners. All of the brochures provided facts about AIDS, for example, that it could be spread through sharing needles or having unprotected sex, but 52% the pamphlets failed to provide information about the severity of the virus. Readers were not told that AIDS was fatal (Perloff & Ray, 1991). They were not shown statistics, graphs, personal narratives, or loss-framing information. As a result, this campaign resulted in very little actual effects on its intended audience (Murray-Johnson & Witte, 2009). Previous studies examining various components of the HBM, including severity, self-efficacy and susceptibility highlight the importance of these variables to health communication research, and
establish the need for the model’s use in IPV prevention and intervention campaign research.

Summary

The past three decades have seen a dramatic increase in the amount of scholarship focusing on IPV (Archer, 2000, 2002). Similarly, the field of health communication, and with it the research into public health campaigns, has drawn increased scholarly attention over the past several decades. However, in the midst of such research into IPV, scholars have failed to adequately incorporate the lived experiences of its victims into meaningful results that can shape public health campaign strategies in the future.
CHAPTER THREE
METHODOLOGY

This study investigated the lived experiences of survivors of intimate partner violence (IPV), who sought help at local domestic violence shelters, as told in their own words, and in turn, investigated the women’s response to IPV campaign ads based on those experiences. The Health Belief Model (HBM) guided the design of this investigation, and allowed survivors’ stories to be told using key constructs that are often used to assess public health campaigns. By listening to survivors’ rendering of their own experiences with IPV and responses to IPV campaign ads, the intent was to develop a conceptual framework for understanding how survivors might view these campaigns differently than the general public, and consequently, how their shared stories might influence campaign design in the future. The data for this study were gathered using multiple methods, including, pencil-and-paper demographic questionnaires, audio-recorded, semi-structured interviews, and artistic drawings. The aim of this investigation was to understand the experiences of survivors of IPV through their own words, and to understand their perceptions of prevention and intervention campaign ads.

Research Questions

The following research questions guided this investigation:

RQ1: What are survivors’ lived experiences with IPV?

RQ1a: What were survivors’ motivations for seeking support?

RQ2: What are survivors’ perceptions of current and former IPV campaign ads?
RQ3: What are survivors’ perceptions of current and former IPV campaign ads in relation to the five components of the HBM?

RQ4: How do IPV survivors depict an ideal campaign ad?

Methodological Paradigm

Traditionally, women have been underrepresented in scholarly research, resulting in a lack of research into women’s health conditions, including IPV. Scholarly focus on quantitative methodology prevents us from understanding women’s experiences in their own words, due to its reliance on standardized scales. The present study will rely on multiple qualitative methods, in order to effectively study the experiences of survivors of IPV.

Creswell (2013) identifies eight strengths of qualitative research. First, qualitative research gives the researcher the chance to “collect data in the field at the site where participants experience the issue or problem under study” (p. 45). Second, qualitative research places the researcher in a key role, as it is the researcher who physically collects the data by “examining documents, observing behavior, and interviewing participants” (p. 45). Creswell notes that qualitative researchers “gather multiple forms of data, such as interviews, observations, and documents” (p. 45). In this way, qualitative researchers have multiple data sources at their fingertips, rather than having to rely on one set of data from a survey, for example. In qualitative work, researchers “build their patterns, categories, and themes from the ‘bottom up,’ by organizing the data inductively into increasingly more abstract units of information” (p. 45). Qualitative work, however, is not simply an inductive process; researchers also “use deductive thinking in that they...
build themes that are constantly being checked against the data” (p. 45). Qualitative research relies heavily on the “meaning that the participants hold about the problem or issue” (p. 47). When dealing with a sensitive topic, such as IPV, understanding the meanings and interpretations that survivors place on the issue is extremely important.

Creswell describes the research process for qualitative design as emergent, meaning “that the initial plan for research cannot be tightly prescribed, and that all phases of the process may change or shift after the researchers enter the field and begin to collect data” (p. 47). The notion of an emergent research design is especially important in focus group interviews that deal with sensitive topics, as participants often want to talk for a long time about their personal experiences. Qualitative research also allows researchers to “position themselves” within the study, meaning that a researcher’s background can, and often does, influence and inform their interpretation of the data. Finally, Creswell writes that qualitative researchers work to provide a holistic account of the issue being studied, in that they bring in multiple perspectives that all contribute to the bigger picture.

The present study endeavors to understand survivors’ experience with IPV, and in turn, how those experiences shape their responses to viewing domestic violence prevention and intervention campaign ads. As such, the participants’ voices are at the center of this research study. Pennington (1999) reinforces the idea of placing women at the center of the research, by claiming it “gives their voices a long-denied privilege; more important, for researchers, it allows the women to be understood in the contexts in which they live, grow, and make sense of their lives” (p. 128).
**Multiple Methods**

A multiple method approach involves the use of different forms of data in order to allow the researcher to draw conclusions that carry stronger dependability (Creswell, 2007). This study utilized in-depth focus group interviews, field notes, and even the survivors’ own artistic rendering of their ideal campaign ad. Webb, Campbell, Schwartz, and Sechrest (1966) promoted the use of multiple methods in one study as a means of eradicating potential biases that could arise from using only one method. Seale (1999) discusses the use of triangulation in qualitative research. He explains the origin of the term, “the term itself is designed to evoke an analogy with surveying or navigation…if only one landmark were taken, the observer would only know that they were situated somewhere along a line” (p. 473). Denzin (1978) lists four types of triangulation: data triangulation, investigator triangulation, theory triangulation, and methodological triangulation. In data triangulation, data is gathered at various points during the research process, and is gathered from different sources. Second, investigator triangulation refers to the use of multiple researchers who study the same data. The third type, theory triangulation, suggests the researcher examine data using different theories in order to aid in the understanding of the phenomena being studied. Finally, methodological triangulation involves the use of multiple methods in order to provide the most well rounded data. In order to strengthen this research, multiple methods were employed. The present study used methodological triangulation in the use of focus group interviews, researcher observation, and participant drawings.
Researcher’s Standpoint

Qualitative research is, by nature, an interpretive process, resulting in the researcher playing an active role in gleaning meaning from the data gathered. A major critique of qualitative research centers on the ability to separate the researcher from the phenomena being studied. Husserl (2006) placed emphasis on the crucial role that the researcher plays during interpretation of data. While the researcher’s experiences are pertinent to the study, those should be bracketed so as to allow the researcher to set aside his/her experiences from those of the study’s participants (Husserl, 2006). Bracketing the researcher’s standpoint does not mean that their experience is excluded entirely during analysis. For this reason, it is important for me to share my personal story before telling of participants’ experiences in order to position myself within the study.

I enter this study with personal experiences that have altered my viewpoint on the issue of IPV. Being a cultural insider means I have to continuously question myself and my data analysis throughout the entire research process. Allen (2002) cautioned cultural insiders against “thinking that she knows the answers to research questions,” especially in circumstances where female researchers may identify with the study’s participants (p. 27).

As someone who has been affected by IPV, I understand both the depth and breadth of this issue and how it can so deeply change the lives of those who come into contact with it. In January 2013, I lost a friend to a murder/suicide at the hands of her husband. While I knew there were marital problems and that he often kept too watchful of an eye on her, constantly checking in, I never imagined it would escalate to the extent
that it did. In hindsight, I see the controlling behavior and the dangers associated with it; however, at the time, I never would have described my friend as being “abused” or as a “victim of IPV.” I now understand that not all IPV is physical, and that psychological control can often carry the same burden as physical abuse. Having the opportunity to reflect on warning signs that I missed, ignored, or misinterpreted has illuminated for me the understanding that IPV occurs everyday to people in all walks of life, and that a deeper grasp of the issue is crucial to reducing its pervasiveness in society. In my first semester of graduate school, I began to wonder how women in romantic relationships come to realize that they are in fact victims of IPV, or at the very least how they decide when and where to seek help. It was at this time that I began exploring IPV within a health communication context, to understand how the mass media talked about women in violent relationships, and I have been researching this topic ever since. I am invested, personally and professionally, in gaining a better understanding of how society can best serve women in abusive relationships, particularly through effective use of communication strategies.

As a cultural insider, I come to this project with my own beliefs and conceptions surrounding IPV and abused women. It is my belief that IPV and its consequences reach beyond the individual, and are greatly affected by public health communication, and in turn personal empowerment, I therefore stem from a health communication perspective. This perspective affects how I research IPV, looking at the issue from both an individual and societal perspective. My interest in health communication stems from my belief that we must empower victims of abuse to recognize the signs of that abuse and to be
equipped to seek help. Thus, my role in this study is to record the personal experiences of survivors of IPV as they share their story and react to print campaign ads. My goal is to listen attentively as these stories are told, and to remain open-minded at every turn, hoping in the end, to be able to describe the phenomena of being a survivor of IPV. My overall hope is to be able to explain the phenomena of IPV in such a way as to influence the design and implementation of public health campaigns aimed at victims of IPV in the future.

**Protection of Human Subjects**

Before data collection could begin, the Institutional Review Board (IRB) at Clemson University was petitioned for review and acceptance of the proposed study. IRB approval occurred on April 16, 2014. Data collection began in October 2014 and concluded in February 2015. Every attempt was made to protect the privacy of the focus group participants. Participants were given pseudonyms so that they could not be identified. Audio recordings, transcripts, and field notes were stored in a locked drawer in the researcher’s office, and will remain there for a period of one year. After that year, all files will be destroyed. Participants were given a summary of the results at the completion of the study.

**Research Design**

Focus groups, a particular type of qualitative interview, were utilized in the present study in order to enable the researcher to listen to multiple voices of survivors of IPV at one time. Additionally, this research design allowed survivors to speak with each other, often eliciting additional comments from participants. Interviewing participants in
settings that were both comfortable and familiar to them, aided the researcher and the 
research process, because participants felt safe in telling their stories.

**Setting.** The focus groups for the present study took place at three women’s 
shelters and two off-site administrative buildings in the southeastern United States. The 
women’s shelters were each located in different counties, providing the researcher with 
participants who were representative of different backgrounds, education, and 
socioeconomic status. Participants interviewed at the women’s shelters were survivors of 
IPV and were currently residing in the local shelters. This location was chosen based on 
the fact that a familiar setting would provide comfort to participants. Participants who 
had moved out of the shelters or who were receiving outpatient counseling services were 
interviewed at the shelter’s off-site administrative buildings.

**Participants.** Participants in this research study included 17 women between the 
ages of 20-59 (M = 33; SD=9.38), who identify as survivors of IPV at the hands of their 
male partner or spouse. Only those women in heterosexual romantic relationships were 
consulted for this study. Most of the participants described their highest level of 
education as a high school diploma, while several had “some college,” and only a handful 
reported earning a Bachelor’s degree. The median yearly household income for 
participants was $24,000. Participants were chosen based on their willingness to share 
their stories in a group setting.

**Participant recruitment.** Participants were recruited through their association 
with two women’s shelters in the southeastern United States. The director of shelter 
services at each shelter was tasked with recruiting participants for this study. The
directors of shelter services were in charge of women both residing in shelter and those receiving counseling services. In this way, the directors had the most contact with the women than did anyone else working at the women’s shelters. The shelter directors approached women who they felt would not be further psychologically harmed by participating in this study, and then presented the women with the necessary background information surrounding the study, in an informal conversational manner, and asked if they would be willing to participate. If they were willing to participate, the shelter director made a record of their name and contact information, for shelter use only, so that they could be contacted about the date and time for the focus groups.

**Sampling.** Purposive sampling was used to select participants based on their past experience with IPV and willingness to speak about that experience. According to Creswell (2013), purposive sampling occurs when the researcher “selects individuals and sites for study because they can purposefully inform an understanding of the research problem and central phenomenon in the study” (p. 156). As Crabtree and Miller (1992) note, purposive sampling is more concerned with gathering information that illuminates the study’s questions, rather than with the representativeness of the sample. Patton (1990) states that purposive sampling is used when participants are chosen due to a particular characteristic, in this case having experienced IPV. The present study examined the experiences of 17 survivors of IPV in heterosexual romantic relationships.

**Data Collection**

Before each focus group began, actions were taken in order to establish rapport with participants. The women were told in general what to expect from the focus group,
and that each session would be approximately 90 recorded minutes, with time before and after for set-up and take-down. Participants were informed that they would be shown a total of six print ads related to IPV and asked a series of questions related to those ads. Participants were also told that they would be asked questions about their personal experience with IPV in past (or present) heterosexual romantic relationships. Participants were told that the questions might at times be uncomfortable due to the subject matter, and that the questions may even appear redundant, as the same set of questions was asked for each print ad shown to participants. Participants were told that there was no right or wrong response, and that they should answer each question in their own opinion. Finally, participants were assured that the focus group was confidential, and they could speak openly during our conversation. Following this conversation with participants, the audio recording was turned on and the focus group began.

**Survey.** Before the focus groups began, participants were given a brief survey that asked several basic demographic questions, such as age, education, and yearly household income. Further, this survey asked participants to briefly describe, in their own words, how long their abusive relationship lasted, whether or not they were currently in an abusive relationship, when and why they decided to seek help, and how they knew where to turn to for help. The researcher endeavored to gather this information in the event that some of the participants did not have the chance to voice their personal stories, or if participants did not feel comfortable sharing certain aspects of their experience with the other group members. In handing out the survey, the researcher was assured a holistic view of each participant’s experience with IPV. Following the completion of the
demographic surveys, the researcher began asking questions addressing components of the six print ads.

**Focus group interviews.** The primary strategy for data collection was focus group discussions, which allowed participants to tell their personal stories the way they wanted. The researcher’s voice was heard when posing the focus group questions or when asking for clarification or more information from participants. This strategy was chosen because it allowed participants to come together and discuss their shared experiences with one another and with the researcher. In this way, focus groups allowed participants who were not as adept at articulating their thoughts to take part in the collective power afforded to them by being amongst fellow survivors (Liamputtong, 2009). The focus groups afforded participants the opportunity to offer their own meanings and interpretations to the topic at hand (Liamputtong, 2009). Further, focus groups “encourage a range of responses, which provide a greater understanding of the attitudes, behavior, opinions or perceptions of participants on the research issues” than would one-on-one interviews (Hennink, 2007, p. 6). Finally, focus group interviews were chosen for the ways in which they provided participants with a friendly, non-threatening environment where they could feel comfortable discussing their opinions and experiences without having the fear that they would be judged or ridiculed by others in the group, because these women all had similar experiences (Hennink, 2007).

A total of five focus groups were held at three women’s shelters and two administrative buildings for those shelters. Three focus groups consisted of three women each, and the remaining two groups consisted of four women each. In putting survivors of
IPV together in focus groups, the researcher aimed to elicit thoughts and feelings from the participants that may not have emerged in an interview with the researcher alone. In choosing a focus group setting, the researcher aimed to allow participants to tell their story, in their own words. For this reason, open-ended questions were used. Before beginning the interviews, participants were told what they could expect from the focus group and that each session would be approximately 90 recorded minutes (M = 68), with time before and after for set-up and take-down. Participants were told not to over-think their responses to questions, as there were no right or wrong answers, and they should speak honestly about their experience and their viewpoints. Before the audio recording began, participants were again assured that the interview was entirely confidential.

The HBM was used to develop a list of questions to be asked of the participants following the revealing of each print ad. The questions used during the focus groups were guided by five of the tenets of the HBM: perceived susceptibility, perceived seriousness, perceived benefits of taking preventative action, perceived barriers to taking preventative action, and likelihood of taking preventative action. Sample questions included: (1) Do you identify with the woman in this ad?; (2) What are some of the barriers to taking action against an abusive partner?; and (3) If you saw this ad, how likely would you be to seek help? (see Appendix A for the complete survey).

**Print ads.** A total of six print ads were chosen for the present study (see Appendix B). Each ad represented a particular facet of IPV: physical abuse, sexual abuse, verbal abuse, and psychological abuse. The researcher felt it important to choose ads that depicted the numerous faces of IPV, as no one experience is the same. In this way, the
researcher hoped to choose ads that provided a more holistic picture of IPV. Both national and international campaign ads were chosen due to a lack of representation of verbal and psychological abuse in ads run in the United States. In order to represent all types of IPV, the researcher needed to obtain ads from outside the U.S. The ads chosen for this study come from both government and non-profit agencies. None of the ads used were stand-alone, as they were all part of a wider campaign aimed towards the prevention and intervention of IPV.

The researcher walked participants through the process of viewing the ads and answering questions about them. Ads were shown one at a time. Two copies of each ad were brought to the focus groups. Participants took time looking over the ad before the researcher began asking questions. The researcher went through questions for each component of the HBM one by one. Many times questions reminded participants of their own experiences, which they shared with the group. All components of the HBM were addressed during each of the five focus groups.

Artistic drawings. Following the conclusion of questions regarding campaign ads, the researcher then asked participants to illustrate their ideal campaign ad. Participants were given drawing paper, pencils, pens, colored pencils, and markers with which to draw. No other directions were given other than that participants could draw an entire ad, part of an ad, or some particular object, message, etc. that they would like to see featured on a future IPV campaign. After participants finished their drawings, the researcher asked each participant individually about their ads using the SHOWeD method (Wang et al., 2004; Wang et al., 1998). The SHOWeD method consists of five general
questions that can be used for analysis: (1) What do you see here?; (2) What’s really happening here?; (3) How does this relate to our life?; (4) Why does this problem exist?; and (5) What can we do about this? In some instances, the researcher asked participants to elaborate on their responses.

**Concluding questions.** Once the illustrations were discussed, the researcher began concluding the interview by asking four closing questions: (1) What advice do you have for other women who are abused?; (2) Are there any warning signs that you would tell other women about?; (3) While you were in an abusive relationship, is there anything you wish you had done differently?; and (4) Do you have anything else to add? Following any further comments from participants, the focus groups were concluded.

**Data Analysis**

Primary data for the present study consisted of transcripts and audio recorded interviews. The audio recordings were transcribed verbatim, resulting in 65 pages of single-spaced data. Transcripts were repeatedly reviewed to ensure overall consistency with the audio recordings. Field notes taken during the course of the focus groups were also used to ensure consistency in the transcripts. In those cases where additional information was necessary, the researcher followed-up with participants in order to ensure transcripts reflected participants’ true experience.

**Open coding.** As its name suggests, this type of coding has no restrictions or limits. The researcher goes through all data collected, word for word, and “categorize[s] a chunk of data on the basis of its coherent meaning-its standing on its own-not by an arbitrary designation of grammar” (Spiggle, 1994, p. 493). When the process of open
coding begins, the data is for the most part a blank slate, open to any sort of interpretation. As Strauss (1987) states, the goal of open coding “is to open up the inquiry. Every interpretation at this point is tentative… Whatever is wrong in interpreting those lines and words will eventually be cancelled out through later steps of the inquiry” (p. 29).

For the present study, the researcher began the process of open coding by reading the transcribed focus group interviews line-by-line, and noted particular distinctions or categories that began to emerge. The researcher then repeated this process for field notes. An initial list of codes was developed using the tenets of the HBM as a guide. These codes included, perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and likelihood of taking action. Overall, the process of open coding produced 19 individual codes related to how survivors described their experience with IPV, how survivors reacted to IPV campaigns, and how survivors described what was wrong with IPV campaigns. A list of categories, within which to place each code, also began to emerge.

**Axial coding.** At this point, the researcher begins to create “a new set of codes whose purpose it is to make connections between categories,” thus resulting in more distinct categories (Lindlof & Taylor, 2011, p. 252). Lindlof and Taylor write, “Axial coding is often used to bring previously separate categories together under an overarching theory or principle of integration” (p. 252). During axial coding, the researcher developed more distinct categories and refined codes that fit within each category. A list of themes was developed in regards to how survivors described their experience with IPV, how
survivors reacted to IPV campaigns, and how survivors described what was wrong with IPV campaigns.

**Selective coding.** Here, the researcher works to develop a theory as to the interrelation of all of the categories (Creswell, 2013). Corbin and Strauss (2008) write of selective coding, “all categories and subcategories now become systematically linked with the central/core category, the one ‘that appears to have the greatest explanatory relevance’ for the phenomenon” (p. 104). The researcher identified five core concepts from the categories and codes identified during open and axial coding. The researcher then determined which codes, or themes, fit into each of the five categories, and discarded those codes that did not fit. The five core concepts and related themes were then used to develop a suggested model for how to design IPV campaigns in the future.

**Conclusion drawing and verification.** Criteria for judging the soundness of qualitative inquiry include credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). Once themes were established, several participants were contacted, through the domestic violence shelters, and asked to provide feedback as to whether the themes were reflective of their own experiences. Triangulation is another form of validation that allows the researcher to further improve the reliability and validity of the study.

The overall goal of qualitative research is not to generalize findings, but instead to analyze and interpret findings based on the experiences of a particular sample. The findings of this research study are thus not necessarily generalizable back to a larger population of women. Nelson (1989) citing Husserl explains that the precise methods
undertaken, “in one study cannot exactly be replicated in another, precisely because the phenomenological method is grounded in, and dependent upon, adhering to the specificity of the experience/phenomenon under investigation.” While the results of this study cannot be generalized back to a larger population, it is entirely possible that certain themes identified may indeed be similar to the experiences and reactions exhibited by other survivors of IPV. Therefore, while the present study has limited external validity, the results are applicable to the population under study, and are also likely applicable to other women who fit the necessary criteria for inclusion in the study.

In qualitative studies, reliability is a unique criterion given the very personal nature of the study. In the present study, the researcher has provided information regarding her position within the study, and as a result, every effort was made to provide transparency throughout the data collection process. Data collection tools are provided in the appendices so that the present study may be replicated in the future.

Methods Summary

This study investigated the reaction of survivors of IPV to print campaign ads meant for prevention and intervention purposes. The purpose of this study was to garner insight into the reactions and opinions of survivors of IPV to campaign ads meant to help them. Data were gathered using audio recorded focus groups, and were analyzed using open, axial, and selective coding for emerging themes. This study enabled survivors of IPV to express their opinions and emotions in their own words, thus providing campaign designers with insight into the intricate world of intimate partner violence.
CHAPTER FOUR
RESULTS

This study investigated the reaction of survivors to IPV print campaign ads designed for prevention and intervention purposes. Eighteen themes emerged during the compilation of statements made by participants in the focus groups. In relation to participants’ lived experiences with IPV (RQ1) and motivations for seeking support (RQ1a), seven themes were found: (1) false sense of security, (2) abuse is complex, (3) controlling behavior, (4) monitoring behavior, (5) isolation, (6) fear, and (7) defeat. In regard to participants’ perceptions of IPV campaign ads (RQ2), three themes emerged: (1) abuse equals bruises (2) misguided questions, and (3) show, don’t tell. Concerning participants’ perceptions of campaign ads in relation to the components of the HBM (RQ3), five themes were found, one for each component: (1) fear, (2) freedom, (3) denial, (4) abuse is a serious but neglected issue, and (5) decision to act comes from within. Finally, in regards to participants’ depiction of an ideal campaign ad (RQ4), three themes emerged: (1) life or death, (2) it will happen again, and (3) you are worth more. These interviews provide insights into the experiences of survivors of IPV, and their opinions on current and former campaign ads.

RQ1: Lived Experiences

The research question for this part of the qualitative analysis was focused on the lived experiences of female survivors of IPV. The research questions asked: What are women’s lived experiences with IPV? Participants discussed numerous behaviors and incidents that were indicative of their relationship with their abusive partner. Through
these discussions, five themes emerged: (1) false sense of security, (2) abuse is complex, (3) controlling behavior, (4) monitoring behavior, and (5) isolation. These themes describe the lived experiences of survivors of IPV as they experience abuse. Further, these themes provide insight into the world of IPV and how experiences can ultimately shape the way survivors view campaign ads. Table 1 details the five themes.

Table 1

Lived Experiences

<table>
<thead>
<tr>
<th>Themes for RQ1</th>
<th>Thematic Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>False Sense of Security</td>
<td>Describes the initial feelings of security and safety experienced by participants as they entered into the relationship with their abuser.</td>
</tr>
<tr>
<td>Abuse is Complex</td>
<td>Describes participants’ explanation of their own experiences as having not begun as physical abuse, but rather as psychological and verbal abuse. Further, describes participants’ insistence that abuse is not always visible bruises.</td>
</tr>
<tr>
<td>Controlling Behavior</td>
<td>Describes ways in which abusers controlled participants’ lives, including how they dressed, how often they saw their family, and when they could leave the house.</td>
</tr>
<tr>
<td>Monitoring Behavior</td>
<td>Describes the consistent monitoring of location and activity without permission. This also included excessive monitoring of participants’ mobile phones.</td>
</tr>
<tr>
<td>Isolation</td>
<td>Describes participants’ feelings of loneliness and separation from family and friends, and for some, literal separation from the outside world.</td>
</tr>
</tbody>
</table>

**False sense of security.** A common theme found in the experiences of many survivors of IPV is that of a false sense of security, in which the initial phases gave every indication of a healthy relationship, thus leading the women to think they had found a decent man. One participant stated simply, “things started off great.” Another woman noted the early days of her relationships were filled with roses and going out to eat. In
explaining how she came to love her husband, one woman said not only “because he was the best person I’d been with,” but continued by recalling a visit by her mom and “the way he talked to my mother just made me see him differently, and I just sort of fell in love with him on the spot.” One participant, who has endured several abusive relationships, explained that they all begin the same way: “You know, they’re charming. They woo you. They wine and dine you. They treat you like a queen.” While not every relationship that begins in these ways will turn into an abusive relationship, participants in this study found that what they thought were normal, healthy relationships soon turned into a nightmare in which their experiences reflect the second theme uncovered.

**Abuse is complex.** All 17 participants in this study reported eerily similar early stages to their abusive relationships. Many participants reported their relationships beginning as the quintessential fairytale romance. All of the women had in common the fact that none of their abusive relationships began with physical violence. Put simply by one woman, “the verbal comes before the physical.” Another participant explained, “When the abuse started, it was mental and emotional. The physical abuse came the last night I was there.” Yet another stated, “It was a lot of verbal, emotional, psychological abuse, financial abuse, sexual abuse. Not a whole lot of physical.” Not all participants experienced physical abuse during their relationships, but for the ones that did, the worst abuse came as they prepared to leave. Explains one woman, “The physical abuse came the last night I was there. He woke up from an eighteen hour nap, beat me bloody, and shot at me with a sixteen gauge shotgun in front of our five year old daughter.” Another woman’s experience was very similar, “… he was shooting at me as I was running across
the yard the last time I left him with our four year old child in my arms.” Yet another participant explains the final assault she endured, “I got up one morning to go to work. He put my head through a wall, broke my glasses, and tried to set me on fire.”

Numerous times throughout each 90-minute interview participants brought up the fact that IPV does not simply refer to physical abuse, a fact they have come to learn and accept after leaving their abusive relationships and seeking counseling. One woman explains that she learned to accept the fact that she was in abusive relationships through counseling, as she “kept seeing the cycle keep repeating itself. Different man, different relationship, [yet the] same scenery.” One participant’s experience highlights the fact that abuse is complex in that it is not just physical abuse, but oftentimes when it begins as verbal abuse it eventually escalates to physical:

Some of the relationships start out like that, verbal, and you kind of brush it off. He worked all day, he’s just mad, he’s blowing off steam, so when he comes in, “you’re a fat cow,” “you’re stupid,” you know in your mind you’re like “he don’t [sic] mean it,” or “he had a long day,” but then you have to look at it another way. When it starts out verbal, it goes to physical, and then it can go from physical to sexual.

An oft-forgotten form of abuse, financial abuse, is all too familiar for one survivor:

I couldn’t go shopping, because the money was for other stuff. The last physical abuse was when my son was getting married and I was going to get a mother-of-the-bride dress, and he, that was the last time he bruised me. He was furious that I was going to spend money on a dress for me to wear to the wedding.
Perhaps the most profound comments that highlight how truly complex abuse is, came from one participant who held on for her child, “You never knew who was going to be coming home to you, if it was going to be the charming one or the mean one. You didn’t know whether to expect flowers or a fist.” Insights garnered from these focus groups revealed the theme that abuse is complex. While there are distinct types of abuse, physical and psychological, for example, participants’ responses demonstrate the complex nature of IPV and the multifaceted types of abuse experienced by victims on a daily basis.

**Controlling behavior.** The third theme that emerged from women’s lived experiences with IPV is that of controlling behavior on the part of the abusive partner. All 17 participants in the study reported at least one incident of controlling behavior during their relationship. One woman explains how her husband controlled her appearance so other men would not look at her in public:

I [have] never been so glad in all my day to put on a pair of blue jeans and walk out in public. Honey, I always had to wear sweats. Sweats. My hair couldn’t be washed, nothing like that, and he would sit in the bathroom when I would take a shower.

Abusers can take controlling behavior so far as to deny their partner’s basic necessities, like electricity. One survivor explains, “He kept cutting the power out. We had built onto our mobile home, and he kept cutting the power off in the box so I wasn’t allowed power in our bedroom, but he was allowed to have power in the living room.” Still other abusers take pleasure in controlling what their partner’s do in their free time. As one survivor
notes, “I have a serious obsession with books and DVDs. So mine would throw my books in the fireplace, rip [them] apart, throw [them] in page by page while laughing at me.”

One woman explained that she was not even given a cell phone, “I wasn’t allowed to have no phone. I wasn’t allowed to have no cell phone these past three years, because he would take it.” Another participant explains how the controlling behavior began before they got married and continues to this day:

We had bought a house together leading up to our wedding, and we moved in. We had a Christmas tree, beautiful tree. We had quite a few ornaments. He decorated the tree, put all the lights up, put all the ornaments on. I loved to ice skate as a girl. I had this ornament, hand painted ornament a girlfriend had made me, and I came out in the evening and I put it on a branch. I came out the next morning, and it was moved. We’re a month away from getting married, and you know, I cried about it. I said, “Why did you do that?” He said, “It’s no big deal. I can’t believe you’re upset.” He said to go ahead and move it, so I put it back. I came out the next morning to go to work and it was moved again. I didn’t confront him about it again. He progressed with each move to this last time we just moved, there is not one single thing that’s visible in our house that I put out. Not one candle. Not one coffee maker. Not one lamp. Nothing. Because if I put this magazine here, he moved it there [sic]. There is not one single thing.

One woman shared her experience of the physical isolation she experienced during her second abusive relationship, which lasted for over a decade, “I was locked in a closet. I was deprived of food. He would give me a five gallon bucket to use.”
This research brought to light how participants’ lived experiences with IPV involved controlling behavior on the part of the abusive partner. In addition to the types of controlling behavior expected, such as dictating what they wore, these interviews revealed other types of controlling behavior, such as denying their partner basic necessities. Still another form of controlling behavior is discussed in the next theme.

**Monitoring behavior.** While this theme, monitoring behavior, could technically fall under the theme of controlling behavior, so many of the study’s participants experienced excessive monitoring during their abusive relationships, that the researcher felt it warranted its own distinction amongst the themes. This theme is marked by the constant monitoring of the participants’ location, phone calls, and computer use by their abusive partner both during and after the relationship. Further, monitoring behavior was found to involve harsh expectations as to how long particular outings should take. After leaving her abusive husband, one woman explains what he would do to get in contact with her, “He’d stalk me, and it went from stalking to I’ll change my phone number, and he’d get it again somehow. He’d text me, ‘Where you at?’” Another participant was certain her ex-husband would find her, “He will always track you down. We’ve got computers now. We’ve got cellphones now. If he wants to find you, he’s going to find you, regardless of where you’re at.” This participant explains how her husband used to monitor her drive to and from work everyday:

[He would] go through your phone. [He would] go through your car. [He would] write down your gas mileage. [He] gives you enough money to get to your destination and that’s it. And you best be home at a decent hour or you’ll get it
when you do get home. He said, “I clocked it. It’s 45 minutes.” It was an hour before I got home because I got caught up in traffic. Yea, that was a mistake that day ‘cause he was waiting outside when I got home.

Another participant also shared a story about arriving home late:

I had saved up money and got a really nice car. [I] paid cash for it. He egged my car and did like $2,000 worth of paint damage to my car because me and my daughter [sic] took too long. We were gone to the store, which is right next to my house for 15 minutes. He said that was way too long. When we got back, he shoved me up against the car. He threw eggs at me, threw them into my car, all over our daughter and everything.

Monitoring behaviors of abusers included going through their victim’s purse, “Even phone numbers that I had put down, even if I didn’t have a name with it, if he found that in my wallet, he would call it.” Another woman says, “some will search you when you come home,” and another chimed in, “You fall asleep and they go through your wallet.” One participant describes what she went through on a regular basis, “He went through my phone everyday at least four times, seeing if I had any different contacts or seeing if I had any new numbers in my phone.” Yet another participant talks about the possibilities if he were to go through her purse and find a phone number, “If you were to write it down, and he calls it. Oh dear God.”

**Isolation.** The final theme concerning women’s lived experiences with IPV is that of isolation. In this case, isolation refers both to the literal, physical isolation perpetrators put their victims through, and also to the feelings of emotional isolation endured by
survivors of IPV. One participant explained that even while out in public, her husband managed to isolate her from everyone else around them, “I’m telling you if I looked up in public, I had to look down.” In order to avoid the rising number of questions from friends and family, her husband, “picked us up and moved us here. So we didn’t have to answer all those questions. We didn’t have to run into family. We had a reason not to go to his mom’s house all the time.” Incidents of abusers moving their partners away from friends and family occur all too often. Another woman shared:

I moved off from my family, and that was a big mistake because I couldn’t see my family. My letters and everything from my mother, he would take them, destroy them. I spoke with my landlord and asked if I could have my mail sent to her house, and she said yes.

When asked if she got to see any friends or family much, one woman replied, “No, not much. My best friend from high school and stuff, I didn’t see them at all. There was [sic] a couple of girlfriends that I worked with that I got to see a little, but not much.”

**RQ1a: Motivations for Seeking Support**

The second part to research question 1, concerns women’s motivations for seeking help. Specifically, this research question asked: *What were women’s motivations for seeking support?* Two themes were found: (1) fear, and (2) defeat. These themes describe both the intrinsic and extrinsic reasons the women sought support. Table 2 describes the two themes.
**Table 2**

*Motivations for Seeking Support*

<table>
<thead>
<tr>
<th>Themes for RQ1a</th>
<th>Thematic Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear</td>
<td>Describes participants’ overwhelming fear of harm to themselves or their children as a reason for leaving.</td>
</tr>
<tr>
<td>Defeat</td>
<td>Describes participants’ realization that abuser would never change.</td>
</tr>
</tbody>
</table>

**Fear.** Two themes were found related to women’s motivations for seeking support. The first of those themes is fear. By far the greatest fear these women had was of something physically happening to their children at the hands of their abusive partner, or of their children becoming further emotionally damaged by witnessing the violence.

When asked what made her decide to seek help, one woman replied, “The look on my daughter’s face. What was going on, that was all I could see. I didn’t want her thinking that was acceptable behavior.” Another explained the final straw, “And then one day he grabbed one of my kids, and that’s when I liked to took things into my own hands, and liked to killed him. I had enough when it comes to my children. You ain’t gonna put your hands on my kids [sic].” Admitting she had gone back to her abuser several times, one participant explained why this time she will stay away for good, “Then this last time, no, I had a child, so I said no, that’s it. I’m not staying in this mess anymore, because she’s not going to be raised in it. This time it’s for good. There is no going back. No going back.” Another participant says she left out of the fear her daughter would be damaged growing up in that environment:

Me and her dad argued a lot, and I just decided it wasn’t right. We were together since we were sixteen, and then we had a kid together. I decided that I wasn’t
going to put up with him treating me that way anymore. So, I really just left for her sake more than anything, because if it was just me, I probably would have stayed.

Another motivating factor for these women for seeking help was fear for their life. They knew their abusers, knew what they were capable of, and genuinely believed the threats made on their lives. Yet even after leaving their abusers, the survivors know all too well the danger is not over. One woman states bluntly, “But if they want you they [are going to] find you no matter where you [are] at. You can be sitting at a red light, and if he wants to kill you, he can pull up beside you and blow your brains out.” Once she had decided to leave, her abuser threatened her, “Mine told me that if I ever got another boyfriend, that he’d come and kill everyone that I had,” and she believed him. One woman made a split second decision to leave and explains, “At that moment, you just go. I ran to the hospital because he was determined [to kill me].” When asked if she ever feared for her life, one woman responded, “I did,” and that’s why she left. Her sister could not be saved, but she was determined not to befall the same fate:

My brother in law killed my sister. He shot her with a twelve-gauge shotgun four times. I lost my sister. It woke me up. So, I started talking to my mom, and she was sending me money. So, I would go to my room and move the bed and push the carpet back and put money there and push the carpet down. When I thought I had enough, I was going [to] leave, and that’s just what I done with that one.
By far the most common motivating factor for leaving was the fear for their children’s safety and emotional well-being. Many women also feared for their own lives, and knew that if they did not escape their situation they would be dead.

**Defeat.** The second theme related to women’s motivation for seeking support is defeat. Two types of defeat were uncovered during these focus groups. The first type of defeat, and the one found with at least one participant in each group, centers around the participants’ sense of defeat and feeling that death would be welcomed. Through this, many of them came to understand the depth of their abuse, and began to realize they needed help. The second type of defeat found these women simply giving up, and understanding that their abuser would not change.

One woman says of the years she spent with her abuser:

> You know, one time I had considered suicide as my way out. I figured there was no other way I was going to get out of this relationship, and I had ruined my life and ruined everybody. You know, my family was tired of it, everybody was tired of it, that you know, I was going one way or another.

Another woman stated, “Not only with just verbal, and him being the way he is, it gets you to the point where you could commit suicide yourself.” In the same focus group, another participant echoed those sentiments, “When you get to that point where it’s absolutely, you feel absolutely no hope, you lose hope, you get those thoughts. And I’m sure everyone in our situation has thought that at least once. Man, if I was dead, I wouldn’t feel any of this.” Of the overwhelming feeling of defeat, this woman responded:
Or come in and be like, I wish tonight was the night. Just pull the trigger and be done with it. I’m tired of hurting. I’m tired of you beating on me. I’m tired of the stitches. I’m tired of the bleeding, the knots. [You] can’t go out in public because you’re black or blue and everybody’s staring at you and stuff. You’re sitting there thinking if he doesn’t pull the trigger, you’re gonna [sic].

Remarking on her sense of failure, a wife of nearly four decades said, “Oh yea, I’ve thought that a lot of times. I’ve gotta get outta here. What is the easiest way to kill myself without it looking like I’m some loser who committed suicide?” She explains her thought process as she realized that life was not worth living:

I felt incredibly alone, incredibly worthless. I wasn’t suicidal. I didn’t want to kill myself, but there’s a part of me, I just felt like, I’m living a nightmare and I don’t know how. I just didn’t see any way out. One of the things that kept me going was [my daughter]. I don’t want her to have that stigma to think about. Like maybe she failed me, maybe it was my fault, maybe. You know, the things people think of if something happens to a parent.

Speaking of her overwhelming sense of defeat, another woman explains how the statistics on IPV do not tell the whole story:

That’s not in any of the statistics. The police department can tell you how many women have died, how many women have been treated for serious injuries at the ER. They can give you all of that. They can’t tell you how it makes you feel. How despondent you are. You become introverted, and you never know what’s coming
next. You are so stressed all of the time, and you feel like death would be an escape.

The second type of defeat found through this research was that of the women giving up and realizing that their abusive partner was not going to change, no matter how hard they tried to appease him and remedy any situation. One participant explains her decision to leave, “I thought I was doing us a favor, because he hated me. [He] said I made him sick. I’ll do us a favor, and I’ll leave and make things easy.” Realizing her husband would never change, one participant declared, “I’m gone, you know. This is it.” Understanding her abuser was never going to change, this woman told herself, “The way I like to think of it is it’s easier for me to leave than it is to stay.” The most poignant response comes from a woman who had yet to leave her abuser, but who came to realize there was no other option, “So what is the solution? The only real solution would be to just say goodbye, isn’t it?”

RQ2: Perceptions of Current and Former IPV Campaign Ads

The research question for this part of the qualitative study concerned how survivors perceived current and former campaign ads. Specifically, the research question asked: What are survivors’ perceptions of current and former IPV campaign ads? Participants shared their initial reactions to seeing the ads for the first time, as well as what they liked and disliked about each ad. Three themes were found: (1) abuse equals bruises (2) misguided questions, and (3) show, don’t tell. These themes provide insight into how survivors of IPV view the campaign ads meant to help them, and further, help to
shape the way campaign design is thought of in the future. Table 3 describes the three themes.

Table 3

*Perceptions of Ads*

<table>
<thead>
<tr>
<th>Themes for RQ2</th>
<th>Thematic Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse Equals Bruises</td>
<td>Describes participants’ perception that campaign ads equate IPV to visible bruises.</td>
</tr>
<tr>
<td>Misguided Questions</td>
<td>Describes how campaigns ask the wrong questions in putting the blame on the victim to leave, rather than on the abuser for his behavior.</td>
</tr>
<tr>
<td>Show, Don’t Tell</td>
<td>Describes participants’ opinion that campaign ads contained too much information, and that the picture and title should tell them what they need to know.</td>
</tr>
</tbody>
</table>

**Abuse equals bruises.** Only one ad shown to the focus groups centered on verbal abuse, while the rest focused on physical violence. In each focus group, at least one participant commented on the fact that the ads, as a whole, made it seem as though IPV is synonymous with bruises and black eyes, when they know first-hand that abuse does not have to involve a fist. In the verbal abuse ad, “Killing Me Softly” a woman’s bullet-riddled face appears with verbally abusive phrases placed all over her face (see Appendix B). Some of the study’s participants reacted to this very quickly, while others took several seconds to formulate their response. When shown this ad, one participant responded immediately and simply said, “yes.” Another responded, “that’s about right.” Still another replied, “I think that’s very accurate.” Reflecting on her own experience, one woman said, “Verbal is the worst I think.” Explaining how she views this ad, another participant responded, “It’s killing her. Each time it’s taking a piece of her.” After seeing this ad, one woman realized her instincts had been right, “After seeing this, I would think,
you know, I was right, his words are killing me and messing up my self esteem.”
Although she liked the ad, this woman felt that a very important component was still,
“But what none of these ads have is the fact that you’re not always going to feel this way.
You can go on without him. You’re not a lazy bitch. You’re not a fat cow. The positive
needs to be enforced too.”
Referencing the “Break the Silence” ad (see Appendix B), in which a woman is
seen crouched in a corner, one participant said, “It almost looks like in this one, you have
to have been battered and beaten down before you can call for help. I’m not saying that’s
what it says, but…” Another woman pointed to the ad and said, “it doesn’t tell you much;
what intimate partner violence is.” Without being able to fully understanding what
constitutes IPV, these women cannot be expected to pay attention to, or identify with,
these ads. On the other hand, she liked the “Killing Me Softly” ad because, “It gives you
information about what intimate partner violence is, what kind of constitutes intimate
partner violence, and it’s not just the physical, it’s the controlling.” Comparing the verbal
abuse ad with the “Break the Silence” ad, one woman said, “This, this [Killing Me
Softly] lets you know that those words, the ways he’s speaking to you, that’s not right.
This [Break the Silence] doesn’t tell you any of that. It makes you feel like you need to
be this [points to woman in the ad crouched in a corner] before you can call [a shelter].”
One participant had a message for her former self, when she was not sure if the verbal
abuse she endured was actually IPV, “You need to be in the shelter just as much as
anybody else does.”
One participant in particular appreciates the focus the “Killing Me Softly” ad places on verbal abuse, “That’s something that I think needs lots more attention is mental and emotional, because if you’re mentally and emotionally abused, if you’re physically abused people can see it, but if you’re emotionally abused it’s hard for people to understand.” Another woman reacts to the ad’s focus on verbal abuse and details the long-lasting effects it can have:

I like this because it does talk about, it is about the verbal abuse. People don’t realize the physical abuse is horrible, it’s terrible, but things like being locked in the closet, which some people would consider physical abuse, that’s horrendous. I can’t even think about that. Living this way for so long hurts so deep. You know your broken bones will heal and things will heal, but these kinds of scars, they stay with you. You know, I’ve been divorced now for fifteen years, and I still struggle with a lot of this. I still struggle.

Still another participant explains the ramifications of verbal abuse:

These are the kind of things that tear you down and leave you a shell of the woman you used to be. Because, when I left, I looked in the mirror and the next day, I was like, “Who am I?” you know ten years ago, I wouldn’t put up with this. I would have stomped his butt. I would never let him talk to me like this. They’re slick and gradual, and they make you believe this stuff. That you’re not good enough, that you don’t do anything right. Nobody else is going to want you.

As one focus group was drawing to a close, a woman pointed to the “Killing Me Softly” ad and said, “I still like this one the best. It still speaks to me the most.” This statement is
very powerful in that, of all the ads these women were shown, the one that speaks to
some of them the most is not one about the physicality of IPV, but rather one about the
hidden bruises and scars these women suffer, yet all but one ad they viewed focused on
physical violence.

**Misguided questions.** The “No More” ad sparked great discussion, as many of
the women had either seen a recent “No More” commercial featuring NFL players or
recognized the woman in the print ad as a character on NBC’s *Law & Order: Special
Victims Unit* (see Appendix B). The ad shown to the focus groups prominently featured
the question: *Why doesn’t she just leave?* The overwhelming reaction to this ad was that
these campaigns are asking the wrong question. In the first focus group of this research
study, a participant saw the ad and stated emphatically, “No.” Asked to elaborate on her
response, she replied:

> Because there are lots of reasons why we don’t leave and it may not be
> understandable to everyone because they haven’t been in the situation, and when
> you’re left with no options, no help, no destination, no money, no nothing, and
> you have to start over from everything to clothes and food for you and your kids,
> everything all the way from towels, linens, food, dishes, I mean everything, and
> not to mention, a house to put it all in.

One participant responded, “That’s hard to answer,” while another said, “It’s not
really that simple.” One woman looked at the ad and said simply, “People don’t
understand.” She went on to say, “When you love a person, and they’re the only one
you’ve got, it’s hard to leave.” In explaining why this is the wrong question to ask, one
participant said, “We ask ourselves that question all the time.” Of the misconceptions behind this question, a participant said:

People need to stop asking, “Why doesn’t she leave?” “She must like it,” you know, “Why does she let it happen?” and start asking, “Why does he do what he does?”, “Why is he forcing her to leave her home.” “Why is he doing this to her?” That should be the focus and not, “Why doesn’t she leave?” putting the blame on the victim.

Echoing this sentiment, another woman said, “There’s lots of reasons why we don’t leave. Ask why we stay. Ask why he does it.” One participant felt that not only was the question misguided, but so too was the entire idea of putting a celebrity on the ad:

With something like this, with her face, I know who she is, she’s on Law & Order. Her face doesn’t need to be on there. If it said, “No More, why doesn’t she just leave?” how about or instead, “Why doesn’t he leave” or “Why aren’t there stiffer penalties for CDV’s (criminal domestic violence)?” That’s just kind of a wasted space. To me, that’s just a waste of space with her face on there.

**Show, don’t tell.** When considering whether or not an ad would catch their attention enough to stop and read it, many women explained that for a multitude of reasons they are not likely to spend time reading an ad on IPV, and thus the importance of having an ad that is eye-catching and visually appealing. Further, because they are not likely to take time to really stop and read the ad, it is crucial for the picture and title to tell the whole story. For the ad titled “Every Week, Another Two Women Escape Domestic Violence,” which features the feet of two corpses with toe tags in a morgue, focus group
participants had a great deal to say. One woman explained why this ad would draw her attention, “Actually, if I walked by this and I seen [sic] toe tags, then I’m going to stop and I’m going to be like, huh, what’s that about? I might not read all this [pointing to paragraph of information on the ad], but then I got the gist of the picture.” While initially stating that the ad did not represent her, one participant changed her mind, “And I like the bottom where it says ‘don’t ignore the early warning signs,’ because after they read those bullet points, they’re going to be thinking, wow, it could be me in the morgue.”

The issue, however, is in whether or not women will actually take the time to read the ads. One participant said of the ad, “I would not even look at that. Too many letters, too many words.” Still another noted, “That’s too much writing.” The busyness of the ad would have deterred her from reading it, despite the image of the corpses. For a graphic ad titled “Falling Down the Stairs,” that featured prominent cuts and bruises, one participant said, “I would have noticed the picture but not so much the message.” Asked to elaborate she responded:

Well, first of all it’s printed very small at the bottom and honestly, when you pass something like that you want to be able to read it quickly, or at least notice the things that are on it quickly, because you don’t want anybody to notice you stopping and dwelling at the picture.

One participant went into detail about what is going to actually get people’s attention:

Well, really I think nowadays people go by color and what’s in the picture, because if you know, you’re reading a billboard, what do they have on it? Big, bright signs. What do they have in a car lot? They’ve got them people waving this
to draw people in. All of this is too much [pointing to paragraph of information on the ad]. I mean it might talk about some good stuff, but ain’t nobody going to sit there and read all that [sic].

**RQ3: Perceptions of Current and Former Campaign Ads in Relation to HBM**

The research question for this part of the study centered on how survivors perceived these ads in relation to the five components of the HBM: (1) perceived barriers, (2) perceived benefits, (3) perceived susceptibility, (4) perceived severity, and (5) cues to action. The question read as follows: *What are survivors’ perceptions of current and former IPV campaign ads in relation to the five components of the HBM?* Five themes were found, one for each component of the model: (1) fear (2) freedom (3) that’s not me, (4) abuse is a serious but neglected issue, and (5) decision to act comes from within. These themes provide insight into how survivors perceive these ads in relation to the components of the HBM, which will ultimately indicate how likely these women would be to take the recommended health action, in this case leaving their abuser. Table 4 describes the five themes.
Table 4

Perception of Ads in Relation to HBM

<table>
<thead>
<tr>
<th>Themes for RQ3</th>
<th>Thematic Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear</td>
<td>Describes the greatest barrier that keeps women from leaving their abusers.</td>
</tr>
<tr>
<td>Freedom</td>
<td>Describes the greatest benefit that propels women to leave their abusers.</td>
</tr>
<tr>
<td>That’s Not Me</td>
<td>Describes participants’ reactions to being asked if they identified with the abused women in the campaign ads.</td>
</tr>
<tr>
<td>Abuse is a Serious but Neglected Issue</td>
<td>Describes participants’ opinion as to whether the ads depict IPV as a serious issue.</td>
</tr>
<tr>
<td>Decision to Act Comes from Within</td>
<td>Describes participants’ opinion that nothing in the campaign ads would make them leave their abuser, but that the decision to leave must come from within.</td>
</tr>
</tbody>
</table>

**Fear.** This theme was by far the most common response to the questions centered on the first component of the HBM. When asked what barriers prevent them from leaving their abuser, one woman responded immediately and emphatically, “Fear.” Upon elaboration, the participant said, “Of him coming after you; of retribution.” Sounds of affirmation could be heard coming from the other women present for the focus group. Another woman concurred, “Killing you or killing one of your family members. Or snatch your kids. You never know.” Yet another woman said, “He’d tell me, ‘If you ever leave me and take my child, I’ll kill you.’” Asked if she believed him. She replied, “Yes, absolutely. You have enough things thrown at your head. Like I said, there was a lot escalating before that physical.” Asked to explain what she felt would be barriers to her leaving, one woman said simply, “I didn’t know what to expect.” This woman’s fear was of her abuser and not knowing what he would do or was capable of doing, but also fear of the unknown and starting a new life.
Freedom. In regards to the second HBM component of perceived benefits, some women found it hard to focus on the positive that could come from leaving because they were consumed by fear, while others were able to imagine a better life. Asked what benefit first comes to mind, one woman responded, “Peace.” When looking at the ad of the bodies in the morgue, one woman said “escaping the abuse period” would be a welcomed benefit. For her, if leaving meant death, it would be okay because she would still have escaped. Another woman said the only benefit she needed was just “getting away,” whatever happened next would happen, and she would worry about that as it came. In seeking advice from a friend, one participant was told “you are making a better life for you and your son,” so she knew she had to leave. Leaving meant “independence” for one participant, and the opportunity to “take back authority over my home.” One thing this woman was most looking forward to after leaving, was being able to “sleep more better [sic].” This woman went on to explain that she had moved away from her family for her abuser, and leaving him meant she was free to return home: “I had made up my mind, once I get my first check, I’m getting on the bus, and I’m going home. I went to the hospital last night, and they wrote me a voucher where I can get on the bus and go home. Y’all can mail me the check. I ain’t even worried about it.”

That’s not me. Of all the components of the HBM, perceived susceptibility received by far the most comments from focus group participants. Even women who did not speak up much other times during the interviews were eager to answer the question as to whether they felt susceptible to IPV when looking at an ad and whether or not they could identify with the woman pictured. Even though each woman’s experience with IPV
is vastly different, overall reports of being able to identify with the ads were very low.

One woman explains seeing the “Break the Silence” ad, “I passed this, I can’t tell you how many times. In bathrooms, in the courthouse when we would go for child support hearings and stuff when I was with him. Never thought I was a victim of IPV.” In one focus group, even though the women felt that the “Every Week, Another Two Women Escape Domestic Violence” ad featuring the corpses in the morgue was “powerful,” they still did not identify with it; “I don’t know that, again, I wouldn’t think my situation was that serious.” Participants who answered the question on perceived susceptibility related to the ad “I Ran Into the Door,” which saw a woman with tattered clothes and bruises sprawled out in an elevator, noted that it did not apply to them. Said one, “I never did that.” Another woman said of this ad, “I’m going to say, ‘you poor thing,’ and ‘if I meet you I’ll try and help you.’” When reflecting on the ads as a whole, one participant remarked, “Those poor women,” effectively distancing herself from the abuse depicted in the ads. Speaking about the “Break the Silence” ad she has seen in bathrooms, one woman said, “Well, the ones I’ve seen are applying to somebody else, not me.” Looking at an ad depicting physical abuse, another participant said, “Well, I go back to this thing of, see this is he’s going to physically hurt her, so I’m already thinking [sliding the ad away] ‘That poor woman over there.’”

**Abuse is a serious but neglected issue.** While many participants felt that most ads depicted IPV as a serious public health issue, they overwhelmingly felt that in totality enough attention is not paid to the subject. Even when acknowledging that the “Killing Me Softly” ad depicted the oft-forgotten verbal abuse, one participant still said of IPV,
“It’s not being taken seriously.” In essence, one ad focusing on verbal abuse does not mean that the ad designers and campaign planners take IPV seriously as a whole.

Responding to whether or not the ad featuring the corpses in the morgue conveyed the severity of IPV, one woman said, “I think more so than the other ones,” because of “the toe tags.” Because the ad revealed the possibility of death, it was deemed more severe than the other ads. One woman said the “Break the Silence” ad made it seem as though abuse was serious because the ad contained “big letters,” and “you can see everything you need to see.” She considers this ad as one that conveys the severity of IPV because it gives her exactly what she needs, a number to call for help in bright white letters, something the other ads either make you search for or do not contain at all.

**Decision to act comes from within.** When answering questions about what, if anything, on the ad would make them decide to seek help and leave their abuser, participants shared some interesting insight. Some ads were more likely than others to make participants say that they would call the number on the ad or visit the website. For example, comparing “Killing Me Softly” to “Break the Silence,” one woman was more likely to call the shelter for the ad featuring verbal abuse, “I honestly think I would have called for that one before I would have called for the other.” Many women said they would probably call the phone numbers depicted on the ads, but that they “probably wouldn’t go.” In trying to explain why this was the case, one woman said, “I really don’t think a sign will change somebody’s mind. That’s your own decision.” Another echoed this sentiment, “A sign will help you know where to go, but it ain’t gonna make you want to leave. That’s with anybody. You have to figure out that you want to leave. Once you
do figure out that you want to leave, a sign would be of some help.” Asked if there was any possibility that if she saw an ad with a different message on it she might look at it and think “I need to leave,” this woman said, “I wouldn’t. After I decided to do this for myself and my child, after I decided to leave, then I would go looking for signs like this, to try and help me get out, but these signs aren’t going to change my mind.” Put simply, the ad is not what is going to make someone feel like they need to leave their abuser, instead the ad may confirm their decision and help them to act upon it.

**RQ4: Depiction of Ideal Campaign Ad**

The final research question for this qualitative study focused on how survivors of IPV describe and illustrate their ideal campaign ad. Specifically, the question asked: *How do IPV survivors depict an ideal campaign ad?* Using paper, colored pencils, and markers, focus group participants were asked to draw what they would like to see on an ad, and then discussed those drawings. Through this process, three themes emerged: (1) life or death, (2) it will happen again, and (3) you are worth more. Table 5 describes the three themes.

Table 5

*Depiction of Ideal Ad*

<table>
<thead>
<tr>
<th>Themes for RQ4</th>
<th>Thematic Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life or Death</td>
<td>Describes participants’ depiction of an ad as showing victims they have two choices: to live or to die.</td>
</tr>
<tr>
<td>It Will Happen Again</td>
<td>Describes participants’ desire for campaign ads to express to victims that their partners will abuse again.</td>
</tr>
<tr>
<td>You are Worth More</td>
<td>Describes participants’ depictions of an ad that imparts a message of hope to women experiencing IPV.</td>
</tr>
</tbody>
</table>
**Life or death.** As these survivors see it, you have two options: you can either live, or you can die, and which one you choose is entirely up to you. As one participant said, “Abuse can lead to death if you don’t get help.” Walking the researcher through her illustration another participant said, “Basically, you’ve got two choices: you can leave and be happy or you can stay and maybe end up dead. [Pointing] That’s a casket.” She went on to say, “One time he tried to kill me, and that’s what made me leave.”

![Figure 1. Choices 1 and 2.](image)

Another participant said that ads should convey to women the fact that death is a real possibility, saying, “There was [sic] many times I thought I’d die before I’d get out.” Reflecting on the ads she had seen, and on what she would like to see, one woman centered on this idea of imparting hope, and the fact that “you’re not always going to feel this way.”
**It will happen again.** After returning to her abuser multiple times because of his apologies, one woman finally realized that he would never change, and that there would always be a “next time.” She described her ad:

Oh, this was him. I was constantly having to watch his every move. You know how they say keep your friends close, your enemies closer, because he was always all the time plotting how to get me anyway he could, to get me. To take the blame off himself and put it on me. Like, “Well she did this, so I had to do this.”

When asked what the flames represented, she replied, “Hell.”

![Figure 2. Hell.](image)

One woman explained the type of message she felt needed to be conveyed: Even though “he says he won’t do it again,” he always will. When asked what message she
would like to see depicted on an ad to abused women, one woman said simply, “Wake up.” Another woman echoed this by saying, “Get help. Get out,” because there will always be a next time.

**You are worth more.** What many of these women want others in abusive relationships to know and to understand, is that they are more than the abuse they currently experience, and that their life has meaning and purpose. A participant explained her unique ad:

A hand for a slap. Because a slap is not no type of love [sic]. Got some positive things to lift them up a little bit [pointing to phrases]. Down here, you’ve got, “You can get away. There is help. You are important You are needed. You are wanted.” Because with a lot of abusers, you hear, “You aren’t nothing [sic]. You aren’t this. You can’t do this. You can’t do that.” That’s how they were raised. That’s what they saw. That’s what they know. Learn to love yourself.
Figure 3. Love Doesn’t Hurt.

Explaining what she would like to see on an ad, one participant said, “It ain’t worth it. It’s hard at first but you don’t have to live like that.” One woman described the message she would want to see, “You don’t have to go through it.” Another woman reflected on the ads she saw during the focus group, and on what she would want to see on future ads, “To me they’re all the same. I would say you deserve better. Respect yourself.”

Results Summary

This study investigated women’s experiences with IPV, and their reactions to campaigns designed for prevention and intervention purposes. Even though each woman’s abuse story was very different, focus group interviews highlighted common
experiences amongst the survivors. Eighteen themes emerged as the researcher coded responses from each participant. With regards to participants’ lived experiences with IPV and motivations for seeking support, seven themes emerged: (1) false sense of security, (2) abuse is complex, (3) controlling behavior, (4) monitoring behavior, (5) isolation, (6) fear, and (7) defeat. For participants’ perceptions of IPV campaign ads, three themes were discovered: (1) abuse equals bruises, (2) misguided questions, and (3) show, don’t tell. In relation to how participants’ perceived campaign ads in relation to the components of the HBM, five themes were found, one for each component: (1) fear, (2) freedom, (3) denial, (4) abuse is a serious but neglected issue, and (5) decision to act comes from within. Finally, in regards to participants’ depiction of an ideal campaign ad, three themes were found: (1) life or death, (2) it will happen again, and (3) you are worth more. The responses from survivors of IPV provide critical insight into their lived experiences with the abuse, as well as their perceptions of the very ads meant to help them escape.
CHAPTER FIVE
DISCUSSION

Intimate partner violence (IPV) is a public health issue that affects everyone, not matter race, gender, or sexual orientation; however, research indicates women are far more likely to experience IPV than men (CDC, 2012; DOJ, 2012; NCADV, 2007; Tjaden & Thoennes, 2000). In recent years, research into IPV has increased exponentially; however, very few studies actually consult the survivors of that abuse. Burnett et al. (2009) call for the exploration of women’s experiences generally excluded from scholarly research, and thus the basis for their participation in this qualitative study. Through the use of focus groups, participants were able to share their stories, in their own words, in order to help scholars, activists, and campaign designers understand the complexities involved in being a victim of abuse. A discussion of the findings for each of the four research questions, as well as implications for future research is presented here.

Interpretation of RQ1: Lived Experiences

Historically, women’s voices have been subordinate to the dominant male voices in society, which has resulted in a group of society that is both literally and metaphorically silenced. Kramarae (1981) asserts that women can be considered a muted group due to the fact that their perceptions and opinions cannot be easily expressed and are not openly welcomed within the dominant male society. In order to counteract this trend in our society, it is essential that women be given the opportunity to tell their
stories. In order to do this, the present study sought to find out how survivors of IPV described their personal stories with abuse and their motivations for seeking support.

In regards to women’s lived experiences, five themes emerged: false sense of security, abuse is complex, controlling behavior, monitoring behavior, and isolation. These themes describe what victims were forced to endure during their abuse, as well as what made them decide to seek help. These themes provide insight into the world of IPV.

The first theme, false sense of security, describes how these women initially thought they were entering into a fairytale romance, as their partners bought them flowers, took them out to nice dinners, and treated them well. By the time their partner changed and the abuse started, both verbal and physical, the women often felt they were already in too deep in the relationship to leave. Through counseling at the shelters where they sought help, the survivors have come to understand the warning signs for IPV, but at the beginning of their relationships, the charming and protective behavior endeared them to their abusers.

Telling their personal stories, the women continuously said that abuse is not just physical, or abuse is complex. All but one ad used for this study depicted IPV as physical violence, most likely due to the fact that this is what people associate with abuse. The ads stayed true to research that says, “The most common places of visible bodily injury to victims of IPV are to the face, neck, upper torso, breast and abdomen” (Mullerman, Lenaghan, & Pakieser, 1996) by showing black eyes, busted lips, and bruised necks. However, focus group participants explained that even though they may have eventually ended up looking like the women in the ads, the abuse never began that way. Instead,
participants reported extensive verbal and psychological abuse, which they considered to be far worse than physical abuse. Previous research has also indicated that victims of abuse report psychological and emotional violence as being more harmful than physical abuse (DeKeseredy & MacLeod, 1997; Fitzpatrick & Halliday, 1992).

All participants reported experiencing instances that describe two of the themes, controlling behavior and monitoring behavior, even if physical abuse was never present in the relationship. Controlling behavior included the abuser deciding what clothes their partner would wear, when they could wash their hair, dictating where and when they could go somewhere, giving an allowance, and saying whether or not they were allowed to work outside the home. This often resulted in the victims “walking on eggshells” and being afraid to do anything for fear of angering their partner. One woman explained that she “just stopped wearing all types of jewelry and stuff,” because her husband would always criticize whatever she was wearing. Similarly, monitoring behavior involved the abuser going through his partner’s purse, going through her cell phone for any new numbers, and checking the gas mileage in her car. Participants’ experiences are consistent with prior research finding that IPV generally involves a range of controlling and coercive actions on the part of the abuser (Dobash & Dobash, 2004).

Many women reported various forms of isolation during their abusive relationships. The most common form, social isolation, involved victims being kept from family and friends. Prior research has directly linked social isolation to IPV (Farris & Fenaughty, 2002; Latta, 2009). As was the case with participants in this study, research has shown, “the size of the woman’s social network and number of contacts is lower in
more severe cases of IPV” (Coohey, 2007). While many of the victims reported social isolation, one woman in particular reported physical isolation, in which she was locked in a closet for days on end.

**Interpretation of RQ1a: Motivations for Seeking Support**

These two themes, *fear* and *defeat* center on women’s motivations for seeking support. When asked why they decided to seek help, many participants talked about their children and the fear of them growing up in an abusive environment. Others talked about the fear of their abuser and the realization that they could end up dead if they stayed. The other theme associated with motivation for leaving is defeat. One aspect of this theme involved victims who had given up on a better life, and instead thought death would be their best option, whether by suicide or murder at the hands of their abuser. Previous research has found increased rates of suicide attempts in victims of IPV (Barthauer, 1999; Humphreys & Thiara, 2003). Fortunately, these women did seek help, and, consequently no longer report feeling as though they want to die, which supports the finding that receiving support in shelters is linked with reduced levels of suicide risk in survivors of IPV (Adkins & Kamp Dush, 2010; Kaslow, Thompson, Brooks, & Twomey, 2000). Other participants came to the realization that their partner was never going to change, and that leaving was the only option. Many reported having gone back to their partner multiple times as a result of apologies and groveling. Given the responses from these women, campaign planners should focus on fear and defeat as motivational factors for helping abused women seek support. Further, campaigns should focus on the emotions of fear and defeat, as well as providing mitigating solutions to aid women in conquering
these feelings. As many women cited fear for their children’s well being and providing them with a brighter future, campaign planners should focus their attention on the idea of children as the ultimate motivating factors for leaving the abusive relationship.

**Interpretation of RQ2: Perceptions of Campaign Ads**

This research question was concerned with how survivors view IPV campaign ads. Four themes were found: *abuse equals bruises, misguided questions, emphasis on the negative*, and *show, don’t tell*. These themes aid in our understanding of how survivors of IPV view the very ads designed to help them.

With the exception of one ad, the participants remarked on the fact that the ads focused solely on physical violence, in other words *abuse equals bruises*. As these women know firsthand, abuse is not synonymous with bruises. It is possible that the reason these ads contain so many references to physical violence is both because that is what is so often thought of in connection with IPV, but also because male dominance is directly associated with the bruised and battered bodies of women (Dobash & Dobash, 1979; Martin, 1976). In featuring what many people perceive to be what IPV looks like, campaign designers alienated their intended audience. Martin (1976) explains why abuse is not just the bruises:

*Wife beating… is a complex problem that involves much more than the act itself or the personal interaction between a husband and his wife. It has its roots in historical attitudes towards women, the institution of marriage, the economy, the intricacies of criminal and civil law, and the delivery system of social service agencies.*
This statement speaks to what focus group participants were trying to convey. Yes, most of their relationships turned abusive, but there was so much leading up to that act of physical violence that is not depicted in these ads. This particular theme can provide learning opportunities for practitioners and other healthcare professionals who have the opportunity to detect early warning signs for abuse in women. It is imperative to impart the message that women do not have to have visible signs of trauma to be a victim of abuse.

This particular theme, *misguided questions*, focuses on the “No More” ad that asks the question, “Why doesn’t she just leave?” This question can be seen in multiple places related to prevention and intervention purposes for IPV, including other print and television ads. For this particular ad, however, the campaign was trying to impart the message that we should stop asking this question, by saying “No More Why Doesn’t She Just Leave?” However, participants zeroed in on the large question “Why doesn’t she just leave?” and did not notice the smaller message “No More.” This was an unintended effect of this campaign, as it elicited negative responses from survivors, a reaction similar to that found in Keller et al.’s (2010) study of IPV campaign messages. This is also a question that victims of IPV are asked far too often, and as a result, they express annoyance and disgust, insult even, at seeing it yet again on this ad. Their responses ranged from “It’s not that simple,” to saying “There need to be signs for men. Why do you beat on her? Does she deserve this? Does it make you feel better as a man?” Campaign planners would better serve victims of abuse if they re-evaluated what questions they are asking in these campaigns, but also how they are asking the questions.
As the focus groups demonstrated, there are several ways to phrase a question that still gets to the root of the same problem. Future campaigns should take into account the experiences of these women as they read an ad that seemingly places the responsibility, and blame, on them for remaining in their abusive relationship.

Throughout the interview process, many participants commented on the overall negative sentiment of the ads, leading to the next theme, *emphasis on the negative*. Some even said it made them sad, and brought them back to the days of their abuse. While campaign designers could argue that was their intended effect, so as to make the women take action to leave their abuser, this appears to have backfired. When follow-up questions were posed as to whether the women would call the phone number on the ads, the majority replied that they would not. This unlikelihood of calling the number is for a multitude of reasons, one of which is the fact that these ads do not give the victims the hope that their situation can get better. Keller et al. (2010) describe pictures on ads, “Women are typically shown in advertising as passive, submissive, deferential, unintelligent, shy, dreamy, gentle, likely to be manipulated, and helpless” (p. 55). This was certainly the experience of the women participating in the focus groups for this study.

The final theme for this research question is *show, don’t tell*. Focus group participants could not stress enough the need for pictures that grab their attention and a brief message displayed prominently. As many explained, they would be too embarrassed to stop and read an ad featuring a battered woman, and as others pointed out, their abusers often timed their trips to the store, and if they did not return soon enough, they
would be punished. Further, complicated phone numbers and long website addresses are not practical for victims to be able to remember, and they cannot write them down because their abuser could easily find them.

**Interpretation of RQ3: Perceptions of Ads Based on HBM**

The third research question focuses on how participants view the campaign ads in relation to the five components of the HBM: (1) perceived barriers, (2) perceived benefits, (3) perceived susceptibility, (4) perceived severity, and (5) cues to action. Based on focus group discussions, five themes were found, one for each component of the model: *fear, freedom, that's not me, abuse is a serious but neglected issue, and decision to act comes from within*. These themes not only demonstrate how survivors view campaigns in relation to the HBM, but they help to formulate the likelihood that these women would follow the recommended health behavior: leaving their abuser.

Perceived barriers refer to what obstacles stand in the way of someone taking a recommended health action. For participants in the focus groups, that barrier was *fear*. This fear referred both to what would happen if they stayed, and did not take the recommended action, but also to what would happen if they left. Rosenstock (1966) writes that if people believe the barriers to be too substantial, they are unlikely to take the recommended action. Perhaps the greatest fear participants expressed was of their abuser killing them if they tried to leave.

Perceived benefits refers to what rewards, both intrinsic and extrinsic, could be obtained by taking the recommended health behavior. While numerous responses were given to this question, they all centered on one theme: *freedom*. Responses included
freedom both from the abuse and its physical and psychological effects, but also freedom
to be able to live their lives as they wanted to live them. Future campaigns should focus
on mitigating the perceived barriers to escaping the abuse by focusing instead of the
benefits rewarded to those women who are able to leave their abusive relationships. By
focusing on the positive rather than the negative, focus group results suggest, these
women are more likely to pay attention and take action.

Perceived susceptibility refers to how much one feels subject to, or susceptible to,
the particular health threat, in this case, abuse by an intimate partner. More participants
than not said they did not identify with the ads, or the theme *that’s not me*. Even though
participants all identify themselves as victims of IPV, they could not make the leap to say
that they identified with the women pictured in the ads. Carcioppolo et al. (2013)
conducted a study examining messages depicting the threat of contracting the human
papilloma virus (HPV), and consequently, how those messages affected participants’
choice to take preventative health action. Their results suggest that participants’
downplay of their own susceptibility to HPV was a defensive reaction to the extreme
threats depicted in the ads. Further, they suggest that when a person receives a
threatening health message with no means of personal self-efficacy, or feeling as though
they could fix the situation, that person is likely to react in defensive denial. The results
of that study could help in explaining why so many participants in the present study did
not feel susceptible to women depicted in campaign ads, despite admitting to being a
victim of abuse. As participants often commented on the excessive amount of physical
abuse depicted in ads, campaign planners should consider increasing the number of ads
focused on verbal and psychological abuse as a means of reaching those women who do not feel susceptible to the typical IPV prevention and intervention ad.

Perceived severity refers to the extent to which a person feels that the chances of a particular health threat are likely. For this component, there were varying answers as to whether an ad portrayed IPV as a serious health threat. Several explanations can be offered for this. While participants all agreed that IPV is a serious issue, when viewing each ad, they had trouble discerning whether or not IPV came across as serious simply by what was depicted on the ad. The women verbally acknowledged that seeing the words ‘violence’ and ‘abuse’ invoked serious images, but when considering the ad in its entirety, it was difficult to make the assertion that they perceived seriousness in their chances of being victim to IPV, resulting in the theme _abuse is a serious but neglected issue_. This is likely due to the fact that many participants did not identify with the women pictured on the ads, and thus could not make a connection between what the ad depicted and their feelings of a high sense of perceived severity to the health threat.

The final theme for this research question is that the _decision to act comes from within_ the victim. Some participants’ claims that victims must decide for themselves if and when they are ready to leave is supported by research showing that women must have the motivation to change their current situation, but also must have the “internal resources” to follow the recommended action (Ajzen, 1991; Strecher et al., 1986). Rosenstock (1974) notes that the component of cues to action is by far the most under-researched component to the entire model (Janz & Becker, 1984; Zimmerman & Vernberg, 1994). The results of this study do not provide a concrete answer as to what
specifically would make a victim decide to leave her abuser. Perhaps the reason for this was one suggested by a few participants when they explained that victims have to first decide for themselves that they want to leave, and then can look to ads to aid them in that process. This is perhaps the most profound finding of the present study, as it gives immense insight into what would ultimately make these women leave their abusive relationships. Results show, though, that the women must first decide for themselves that they have had enough and that it is time to leave. This begs the question, then, what can future campaigns do to encourage women to leave their abusers? These findings indicate campaigns should contain messages of affirmation that it is time to get out and that life will be better once they leave.

**Interpretation of RQ4: Depiction of Ideal Campaign Ad**

The final research question for this qualitative study concerned how participants depicted their ideal campaign ad through the use of paper, colored pencils, and marker. Through participant drawings and subsequent discussion of those drawings, three themes were found: *life or death, it will happen again,* and *you are worth more.* These themes serve to depict, through art and words, the types of ads survivors of IPV would like to see.

Throughout the interview process, participants often discussed the fear that they would be killed if they tried to leave, but also of the freedom they would experience if they escaped. In describing their ideal ad, both in a drawing and through verbal statements, two women in particular focused on the fact that victims have two choices: *life or death.* Every participant in this research study described experiencing more than
one instance of abuse at the hands of her intimate partner. Many of these women were subjected to years, months, and decades of verbal and psychological abuse first before it turned physical, while some others experienced physical abuse from the beginning, and still others were never physically hurt. One participant who returned to her abuser numerous times, knew immediately what she wanted her illustration to depict: *it will happen again.* No matter how many times they apologize, it will happen again. When asked what message they would most want to see on a campaign ad, several women stated that they wanted messages of hope. They wanted to know that it could, and would, get better. They needed to hear, "*you are worth more.*” Arias and Pape (1999) assert that campaign designers need to consider their intended audience’s psychological state before assuming that a victim is ready and willing to leave her abuser. Further, Arriaga & Capezza (2005) suggest that victims “will likely benefit from interventions that focus directly on eliminating beliefs that reinterpret the partner’s behavior, reducing symptoms of psychological distress, and increasing self-esteem” (p. xx). They continue by suggesting that increasing self-esteem will in turn help the victim reach a place where s/he is ready for self-sufficiency.

**Limitations**

Currently, there are gaps in health communication research and successfully applying that research toward improving health outcomes (Kreps, 2012). Further, although research on IPV has increased in the last several years, only a fraction of those studies actually interview survivors of the violence to help best understand how to reach others like them. As such, this qualitative research study incorporates and seeks to
advance both areas of research. More specifically, this study provides insight into the lived experiences of survivors of IPV, and how they perceive prevention and intervention campaign ads in connection to their likelihood of taking the recommended health action of leaving their abuser. However, this study is not without its limitations. First, this research is limited by the quantity of participants. Although 70 women were contacted for participation in this study, only 17 agreed to take part in a focus group and have their voice recorded. There is a need to expand the sample size in the future. Second, this study focused on the experiences of primarily Caucasian-American women living in the southeastern United States, and thus generalizations should not be made to other groups. Third, the present study focused solely on heterosexual romantic relationships, leaving out homosexual abuse. Fourth, this study utilized only print campaign ads, and did not look at other formats, such as radio and television. Additionally, given the sensitive nature of this topic, it is plausible to suggest that some participants were not completely honest during the focus groups, in that they did not speak up when a particular situation pertained to them, or that they did not tell the entire story. Finally, the women in each focus group were interviewed only once, and with an issue like IPV, it could take a long-term, longitudinal study to truly unpack the issue.

From the results of this study, it is reasonable to suggest that further attention be paid to increasing understanding of IPV survivors’ perceptions of campaign ads in an effort to influence design of future campaigns. Future research should focus on allowing women to tell their stories, in their own words, so as to counteract the historical tradition of excluding women’s voices from scholarly research. Further, there exists a great need
to uncover specific cues to action that would increase the likelihood of women taking the recommended health behavior of leaving their abusers. The findings of this study provide numerous ways in which campaign ads can be improved upon, and created anew, and thus a study testing new ads on survivors of IPV is strongly encouraged.
CHAPTER SIX

CONCLUSION

The intent of this qualitative study was to give survivors of IPV a platform on which to voice their first-hand experiences with abuse, and to provide feedback on current and former IPV campaigns based on their experiences. The purpose was to explore and describe the communicative reactions of survivors of IPV to violence prevention and intervention campaign ads. Through the use of focus groups, the researcher was able to capture the lived experiences of victims of IPV, and how those experiences shaped the ways in which they viewed campaign ads meant to help them escape abusive relationships. Further, the use of focus groups allowed participants to share their personal abuse stories, so as to represent their lived experiences in their own words, and to illustrate their ideal campaign ad. Eighteen themes were found concerning these experiences, perceptions of ads, and illustrations of ideal ads. The results of this study provide insight into the lived experiences of survivors of IPV, and how those women view campaign ads designed for intervention and prevention purposes. Results from this study may have implications for future research on the subject.

A topic of conversation in every focus group for this study was the misunderstanding and confusion surrounding IPV by the general public. There exists a great need for providing the public with opportunities to expand their understanding of the issue. Current literature and educational materials and campaigns on IPV should be expanded to include more information on verbal and psychological abuse, as well as information not just on how to prevent an abusive relationship, but on how to escape one,
and on how to live life post separation. These efforts may help not only those suffering from abuse, but the public at large in providing education for a better understanding of the issue, and for how to help a friend or family member in need.
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APPENDICES
APPENDIX A

Re-Shaping Our Vision of Domestic Violence: A Qualitative Analysis of Survivors’ Reaction to Existing Communication Campaigns

INTERVIEW SCRIPT

Hello, my name is Alex Neal, and today I will be asking you a series of questions about some domestic violence advertising campaigns that I’m going to show to you. Our session today will be audio recorded, but any personal information about yourself, such as your name, hometown, identifying physical characteristics, etc. will be kept completely confidential. I have chosen to audio record our session today so that I can better focus on our conversation rather than trying to write down everything you say, which would be virtually impossible. The audio recording will be used to help me write my research report.

First, I will show you a print advertisement from a campaign, and then will ask you a series of questions related to the advertisement. After that, I am going to give you each white paper and colored pencils/crayons so that you can draw for me what you would want to see on a domestic violence awareness advertisement. You don’t have to be an artist to do this; I just want to get a better idea of what you, as survivors, would put in these advertisements if you were to design them yourselves. You can even use words and phrases to illustrate your thoughts, if you’d like.

My interest in studying domestic violence runs deeper than conducting these focus groups and writing a paper for school. I have personal experience with this issue and want to see more research done on how we can effectively reach women who are most at risk and help them before it is too late. I plan to be involved in domestic violence projects and awareness for many years to come.
Demographic Questions:

1) How old are you?
2) What is your race/ethnicity?
3) What is the highest level of education you have received?
4) What is your yearly household income?
5) Were you (in the past) or are you (currently) in an abusive relationship?
6) How long did your abusive relationship last?
7) What was/is your relation to the abuser?
8) When did you first start seeking help for the abuse?
9) Why did you decide to seek help for the abuse?
10) How did you decide where to seek help?

General Introduction Questions:

1) What is/was your experience with domestic violence?
2) What made you seek help?
3) How did you decide where to get help?
4) Have you ever seen an awareness/prevention ad for domestic violence?
   a. If so, please explain which one(s).

Now, let’s take a look at some current domestic violence campaign advertisements. Show participants each ad, one at a time and ask the following questions for each.

Perceived Susceptibility to Domestic Violence:

1) Could something like this happen to you?
   a. If so, is this what your experience looked like?
   b. If this is what your experience looked like, would you tell someone?
2) Could something like this happen to someone else/someone you know?
   a. If so, would their experience look like this?
3) Do you identify with the woman in this ad?
   a. If so, what about her makes you identify with her?
   b. If not, what about her distances you from her?
4) How would you change the ad to make it more identifiable with your experience?

Perceived Seriousness of Domestic Violence:

1) Is domestic violence a serious public health issue?
2) What does this ad say to you about the seriousness of domestic violence?
   a. If numbers, do the numbers make domestic violence more serious?
   b. Do the numbers mean anything to you?
3) What does this ad say about the types of domestic violence that exist?
   a. What does this ad say about the types of DV that do not exist?
4) How would you change the ad to make domestic violence seem like a more serious issue?

**Perceived Benefits of Taking Preventative Action:**

1) What are some things you could do to take action against an abusive partner?
2) What would be some benefits of taking action against an abusive partner?
3) How would it affect your life if you sought help?
4) How would you change the ad to emphasize the benefits of taking action?

**Perceived Barriers to Taking Preventative Action:**

1) What are some of the barriers of taking action against an abusive partner?
2) If you did not take action, how would it have hindered your situation?
3) How would it affect your life if you did not seek help against an abusive partner?
4) How would you change the ad to minimize the barriers of taking action?

**Likelihood of Taking Recommended Preventative Action:**

1) If you saw this ad, how likely would you be to seek help?
   a. If so, how?
   b. In what ways?
   c. What specifically about this ad would make you seek help?
   d. If not, why?
2) How would you change the ad to persuade women to seek help against abuse?

Now, I’m going to give you some white paper and colored pencils/crayons for you to draw your ideal advertisement. You can put whatever you would like on this paper. This is an opportunity for you to have a say in how domestic violence campaigns are designed. After you draw your ad, we’re going to come back together and talk about what you’ve drawn.

*Allow participants 10-15 minutes to draw their own advertisement and then discuss each one.*

**Questions for Illustrations:**

1) What do you see here?
2) What’s really happening here?
3) How does this relate to your life?
4) Why does this problem exist?
5) What can we do about this?

I just have a few closing questions for you all before we conclude the session today.
General Closing Questions:

1) What advice do you have for other women who are abused?
2) Are there any warning signs that you would tell other women about?
3) While you were in an abusive relationship, is there anything you wish you had done differently?
4) Do you have anything else to add?

In conclusion, I’d like to tell you more about my personal experience with domestic violence. On January 28th, 2013 my friend Rose, who worked for the university where I received my undergrad, did not show up to work. Countless phone calls, texts, and emails went unanswered. Around 6:30 that evening I received a phone call from a professor whom I am close with telling me that Rose had been killed. Her husband shot her multiple times and then turned the gun on himself. There were never any signs of physical abuse in their marriage, but I knew she no longer loved him and wanted a divorce. I also knew that he was very dependent, he constantly texted her, he was obsessed with her beauty and how they looked as a couple. Looking back, there were warning signs. Because her children seemed to blame her wanting to leave for their deaths, they wanted to just sweep the matter under the rug and never talk about it again. That did not sit well with me, so I began researching domestic violence myself and soon found that there was a clear lack of research in how survivors of domestic violence react to all of the efforts to reach out to them. That’s why I’m here today.

I sincerely thank you for your participation in this focus group today. If you would like, I would be happy to send the shelter a copy of my research report once it is completed. This way, you can see how our conversation today will help to further domestic violence research.
Domestic Violence...
Break the Silence

Call For Help
1-800-260-9293

YouBreakTheSilence.com
I FELL DOWN THE STAIRS

VIOLENCE BY INTIMATE PARTNERS. Violence by intimate partners occurs in all countries and cultures, although some populations are at greater risk than others. The overwhelming burden of partner violence is borne by women at the hands of men. Studies show that 48-70% of female murder victims are killed by their husbands or boyfriends, frequently in the context of an ongoing abusive relationship. In some countries as many as 67% of women report being physically assaulted by an intimate male partner at some point in their lives.

Violence by intimate partners can be prevented. For more information, visit www.who.int/violence_injury_prevention
Killing Me Softly With His Words.
Domestic abuse is not just physical;
Verbal abuse destroys lives.

You're lucky to have me
You never do anything right
You can't go out without me
You're a waste of space
Stupid cow
I hate you, I love you
Lazy bitch
Who were you talking to
Your opinion is worthless
Keep your mouth shut
You'll never amount to anything
Your friends don't like you

Sonas Housing Association www.sonashousing.ie  Viva House Women’s Refuge 01 8662015
NO MORE

"WHY DOESN'T SHE JUST LEAVE?"

Domestic violence and sexual assault are never the victim's fault. It's time we all speak out to stop the violence.

No more excuses.
No more silence.
No more violence.

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www.nomore.org
Tamera Tunie
SEXUAL VIOLENCE: Available data suggest that in some countries nearly 1 in 4 women report sexual violence by an intimate partner, and up to one-third of girls report forced sexual initiation. Data also suggest that hundreds of thousands of women and girls throughout the world are bought and sold into prostitution each year, or subjected to sexual violence in schools, workplaces and health care institutions.

Sexual violence can be prevented. For more information, visit: www.who.int/violence_injury_prevention

Global Campaign for Violence Prevention
Campagne mondiale pour la prévention de la violence
Every week, another two women escape domestic violence.

According to the Home Office, two women in England and Wales are killed by their partner or ex-partner every week.

At Refuge, we’ve learned in our 37 years that what starts as a slap or shove can escalate into a pattern of frequent brutal beatings, and can even lead to death.

We’ve learned that far from being about losing control, domestic violence is actually about men taking control.

And we’ve learned that emotional abuse can do a huge amount of harm.

Forewarned is forearmed, so Refuge would like to alert you to some of the early warning signs of domestic violence.

- Is the man in your life charming one minute and terrifyingly aggressive the next?
- Is he excessively jealous and possessive?
- Is he stopping you from seeing your family and friends?
- Is he constantly criticizing you and putting you down in public?
- Does he control your money?
- Does he tell you what to wear, who to see, where to go, what to think?
- Does he pressure you to have sex when you don’t want to?
- Are you starting to walk on eggshells to avoid making him angry?

Don’t ignore the early warning signs. www.refuge.org.uk

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