Primary Health Care Research & Development 2013; **14**: 350–359
doi:10.1017/S1463423612000473

RESEARCH

Give me 'strength to change': insights into a social marketing campaign in the North of England

Gill Thomson[1], **Nicky Stanley**[2] and **Pam Miller**[3]

[1]Research Fellow, School of Health, University of Central Lancashire, Preston, UK
[2]Professor of Social Work, School of Social Work, University of Central Lancashire, Preston, UK
[3]Research Fellow, School of Social Work, University of Central Lancashire, Preston, UK

Aim: In this paper, we report on how formative research was utilised to design a social marketing campaign commissioned by a Primary Care Trust within an area of high social deprivation in the North of England. **Background:** Men represent the majority of perpetrators of domestic violence and there is increasing interest in developing services for this group with the aim of changing abusive behaviour. However, men are known to be less likely to engage in help-seeking behaviours, and this reticence has been attributed to the social construction of masculinity. A further barrier for men seeking help in relation to domestic violence is the cultural construction of domestic violence. **Methods:** Formative research was undertaken to explore the perceptions and attitudes of a community population of males ($n = 84$). Focus groups explored barriers and drivers to help-seeking and identified effective communication messages. **Findings:** These findings were translated into the 'Strength to Change' campaign that minimised stigmatisation and blame while emphasising help-seeking as a 'strength' rather than a perceived weakness. Social marketing techniques facilitated an in-depth appreciation of local barriers to help-seeking and generated context-specific messages to encourage take-up of a new service for male perpetrators.

Key words: domestic violence; formative research; perpetrators; social marketing campaign

Received 30 March 2012; revised 19 June 2012; accepted 3 September 2012; first published online 8 October 2012

Introduction

This paper describes the formative research undertaken to inform a social marketing campaign that aimed to stimulate take-up of a new local service for male perpetrators of domestic violence. The campaign started from the premise, based on existing literature, that men would be reluctant to access such a service. Research has identified that men are consistently less likely to access health services (White, 2006; White and Banks, 2008); particularly in relation to seeking help for psychological or psychiatric difficulties (Care Services Improvement Partnership (CSIP) and National Institute for Mental Health in England (NIMHE), 2006; Maclure *et al*., 2006).

One of the key explanations for men's reticence in help-seeking relates to the social construction of masculinity. A review undertaken by Galdas *et al*. (2005) into men and help-seeking behaviour identified 'traditional masculine behaviour' as an explanation for delays in seeking help among men who experience illness. The pre-formed male ideal is to be superior, strong, invulnerable, independent, powerful and in control (Bagshaw *et al*., 2000; Mahalik *et al*., 2003). A man who is ill and who admits a need for, or relies on others for help and support falls short of this image of

Correspondence to: Dr Gill Thomson, School of Health, University of Central Lancashire, Preston, PR1 2HE, UK. Email: GThomson@uclan.ac.uk

manhood (White and Johnson, 2000). Help-seeking behaviours, generally considered to be feminine traits, signifying weakness, are associated with a lack of status, control and independence (Moller-Leimkuhler, 2002; Chan and Hayashi, 2010). Studies also suggest that men view mental health problems with 'fear and aversion' (Maclure *et al*. 2006) and are concerned about the stigmatising label of a mental health problem (CSIP and NIMHE, 2006). Men have also been found to express a lack of trust in statutory service provision, together with concerns about confidentiality concerning disclosures of poor emotional health (O'Brien *et al*., 2005; CSIP and NIMHE, 2006).

Social norms and barriers similar to those identified in the wider help-seeking behaviours literature have also been reported for men who perpetrate domestic violence (Hester *et al*., 2006; Levitt *et al*. 2008). However, an additional deterrent to help-seeking for abusive men concerns the way in which domestic violence is perceived and portrayed. Although there is general consensus that men (including perpetrators) do not generally condone violence against women (Pavlou and Knowles, 2001; Craig *et al*., 2006), men express the belief that violence is justified under certain circumstances (Donovan *et al*., 1999; Pavlou and Knowles, 2001; Craig *et al*., 2006; Yamawaki *et al*., 2012). Various studies have found that male perpetrators attribute shared blame for the violence to their victims (Dobash *et al*., 2000; Winstok *et al*., 2002). Although abusive men have been described as expressing remorse, guilt or shame about their behaviours, such self-admonishments are often accompanied by exculpatory statements designed to blame the victims and legitimise their own behaviours (Donovan *et al*., 1999; Dobash *et al*., 2000; Cavanagh *et al*., 2001; Bonomi *et al*., 2011).

Further cultural barriers to men identifying their behaviours as abusive relate to the stereotypical image of an abusive man as a physically violent, out-of-control alcoholic; with these images operating as a disincentive for men to seek out professional help (Bagshaw *et al*., 2000). Abusive men have been found to reject or express frustration at labels such as 'batterer' or 'abuser' (Cavanagh *et al*., 2001). Men have also conveyed a 'siege mentality' when 100% of blame is attributed to male abusers (Donovan *et al*., 1999). However, even when abusive men recognise they need help to prevent and stop their violent behaviours, they are often unaware of where and how to access services (Hester *et al*., 2006).

It is increasingly acknowledged that initiatives aimed at ending domestic violence need to target and engage men as the primary perpetrators of abusive behaviour (World Health Organisation, 2007). Furthermore, it is argued that the widespread nature of domestic violence calls for preventative approaches that aim to change attitudes, values and behaviour at the level of the community in addition to interventions targeting the individual (World Health Organisation, 2007). The last few years have witnessed a growth in interest, research and practice in social marketing by policy makers, practitioners and health professionals (National Social Marketing Centre, 2009). Although social marketing has its roots within the commercial sector, it is frequently utilised to influence health and social behaviours (Donovan *et al*., 1999; McKenzie-Mohr, 2000). Through a strategically applied mass communications campaign (often accompanied by the design and implementation of appropriate services), the end goal of social marketing is to improve individual well-being and social welfare by reducing or replacing negative behaviours by promoting and encouraging positive alternatives.

One of the principle features of social marketing is that the consumer is located at the crux of its design, and formative research with the target population is usually undertaken to inform the content and delivery of a campaign (Andreason, 1995; Department of Health, 2008). Social marketing is increasingly being utilised within a number of public health arenas such as sexual health (Montoya *et al*., 2005), healthy eating (Dutta-Bergman, 2003) and alcohol abuse (Gordon *et al*., 2010). A number of recent campaigns have also focused on addressing violence with young people and/or adults (Quinn *et al*., 2007; Mbilinyi *et al*., 2008; Potter and Stapleton, 2011). The social marketing campaign reported here was influenced by the *Freedom from Fear* campaign developed in Western Australia (Donovan *et al*., 1999). The campaign targeted men who were engaged in, or at risk of, domestic violence and involved a mass media advertising campaign supported by a men's domestic violence helpline. The helplines staffed by trained professionals offered counselling support and encouraged access to perpetrator programmes. Two years after the campaign was launched, over

Table 1 Focus group participants' experience of domestic violence

Nature of previous experience of domestic violence	Yes		No	
Previous experience of domestic violence as child	17	20%	67	80%
Previous experience of domestic violence as victim	18	21%	66	79%
Previous experience of domestic violence as perpetrator	12	14%	72	86%
Any previous experience of domestic violence	32	38%	52	62%

6000 calls had been made to the helpline with approximately half accepting a voluntary referral into a behaviour counselling programme (Gibbons and Patterson, 2000).

The social marketing campaign described below was delivered in the city of Hull in North-East England in 2009 and again in 2010. The city is characterised by high socio-economic deprivation, unemployment and low educational attainment. Estimates based on police figures suggest that rates of domestic violence are high particularly in areas dominated by public housing (Hunter, 2010). Attitudinal and social change has been slow to reach this city and traditional conceptions of gender roles remain prevalent. This paper describes formative research undertaken with local men that explored their perceptions of help-seeking in relation to men's abuse of women. An earlier paper (Stanley *et al*. (2012a, forthcoming)) reported their understandings of domestic violence and motivation to change. Here we describe how men's views on help-seeking informed the development and delivery of the campaign.

Methods

Fifteen focus groups were held across the city in 2008 with a total of 84 men aged between 17 and 72 years. Recruitment strategies were designed to reflect the target population identified for the campaign and focused on engaging men who represented the diversity of the local population, as well as including those who had/were more likely to perpetrate violence.

Eight general public groups ($n = 43$) were convened through workplaces (including manual, skilled and professional workers) and community organisations, namely a sports club, a local church and a children's playgroup. Third-sector organisations were approached and focus groups held with a black and minority ethnic group (BME, $n = 6$) (included to represent the small local BME population); an older people's group ($n = 6$); a young people's group ($n = 9$) and a family support service users group ($n = 3$). Two focus groups ($n = 14$) were held with men recruited through local substance misuse services who represented a group at high risk of perpetrating domestic violence, and one with participants involved in a perpetrators' treatment programme ($n = 3$). Table 1 shows that, when invited to disclose previous experience of domestic abuse on an anonymous tick-box form, 32 (38%) of the participants had witnessed or experienced violence as a child and/or had been a perpetrator of violence within an intimate relationship.

Two male researchers facilitated all focus groups utilising a structured interview schedule that explored participants' conceptualisations, attitudes and perceptions of domestic violence; their opinions on current government definitions of domestic violence and why violence occurs in interpersonal relationships; barriers and factors to seeking help for abusive behaviour and ideas on what messages should be utilised within a social marketing campaign. Individual scorecards that required participants to assign rankings to motivating messages (eg, effects of violence on children, worried about losing wife/girlfriend, knowing help is available, getting into trouble with the law) and different sources of help (eg, police, general practioners (GP), friends, telephone helpline) for abusive men were also used.

The focus groups took between 60 and 90 min to complete and were digitally recorded. Informed consent procedures were adopted for all participants who have been anonymised in this paper.

All digital recording were transcribed in full. Scorecard results were entered into SPSS v16 for descriptive analysis. Basic thematic analysis was undertaken by two members of the research team assisted by the NVivo software package. An initial coding framework was developed via

repeated readings of the transcripts. Each transcript was then read against this framework, with modifications made as appropriate, until firmer concepts and hypotheses were identified. All analytical decisions were discussed, refined and agreed by two researchers.

Ethical approval for the study was obtained from the sponsoring University's Ethics Committee and the study was conducted in line with National Health Service research governance procedures.

Results

Men's attitudes to help-seeking

Consistent issues emerged in relation to the barriers that abusive men face in seeking help. Disclosing domestic violence was considered to evoke feelings of shame, stigma and embarrassment. Social opprobrium was an anticipated consequence of disclosure:

> *Your friends could judge you… you could be judged and somebody could come back to you and it could affect you in another way.*
>
> (Family Support Services Users Focus Group)

Furthermore, the fear associated with the potential for legal and social consequences was believed to exacerbate men's reticence:

> – *Being petrified of what could happen if it comes out.*
>
> ….
>
> – *Like whether, like involving the Police and everything I think a lot of people will be absolutely petrified.*
>
> – *If you went in looking for help and they went and turned around and tried to charge you.*
>
> (General Public Group 1)

A further barrier concerned men's reluctance to discuss sensitive issues, with 'opening up' and sharing problems perceived as feminine characteristics:

> *…the way the female brain is made is they'll talk about more freely, give finer details than the men, men tend to be a bit reluctant to open up when they've got a problem … men are not made like that.*
>
> (BME Group)

Acknowledging domestic violence

All focus groups identified the importance of acknowledging violence as a precursor to seeking help. It was generally agreed that men needed to recognise they had a problem before help-seeking would occur:

> *…the person in question would have to admit that they had a problem first because if they didn't admit it they might just carry on regardless, if they sort of are self-aware, really I've got a problem, I've got to do something about it.*
>
> (General Public Group 3)

In common with other research, participants argued that any campaign would need to avoid stereotypical images of perpetrators of domestic violence if men were to identify themselves as abusive:

> *…people have this perception of what an abuser looks like and it's…anybody…. It's the guy that's wearing the suit and in a fantastic job, with a nice house and a big car and all the rest of it, or it's the guy working on the building site or taking orders at McDonalds…*
>
> (Perpetrators Group)

Sources of support

Group members were provided with a scorecard to rank from 1 to 5 the likelihood of a perpetrator using different sources of support. As Table 2 identifies, telephone helplines were considered to be the most likely form of support to be used by abusive men, with just under 74% giving this a high rating. GP, friends and relatives were rated highly by ~40% of participants, with the police and work colleagues rated highly by <10% of group members.

Further discussion about telephone helplines identified anonymity as a key precondition for

Table 2 Sources of support rated as likely or highly likely to be used by abusive men by all group participants

Sources of support	Frequency	%
Telephone helpline	62	73.8
GP	36	42.9
Friends	35	41.7
Relatives	32	38.1
Police	8	9.5
People at work	8	9.5

https://doi.org/10.1017/S1463423612000473 Published online by Cambridge University Press

seeking help, particularly when men were disclosing their identities as perpetrators of domestic violence. Participants argued that the anonymity conferred by a helpline avoided damaging others' views of them, sidestepped judgmental attitudes and was a defence against police or social services' involvement:

> *…everyone has like a face that they show the public or everyone around them, especially at work, I mean you don't want to be speaking to someone at work and then next minute everyone in the office is giving you mucky looks because they all know you're a bit of a, you know.*
> *– Wife beater.*
>
> (BME Group)

Helplines were favourably compared with other forms of support due to the immediacy of access. Being able to exert control over the help received, such as the length of the call, was also cited as key to the high rating assigned to this type of support:

> *Put the phone down if it gets too much.*
>
> (General Public Group 1)

Accessibility of services was seen as critical. Group members argued that too often services were promoted to the public, but limited availability meant that long waiting periods minimised their impact:

> *the worst thing you could do is say 'oh no there's nobody available to talk about that right now, why don't you ring back','cause that person ain't ever going to ring back, you've lost that one and only chance.*
>
> (Family Support Group)

However, although participants agreed that a helpline was the most likely source of support for abusive men, they also emphasised that self-acknowledgement of their behaviour would need to precede seeking help. A member of the perpetrators group talked from his own experience:

> *I probably wouldn't have rang it because in my mind …. I wasn't doing anything wrong.*
>
> (Perpetrators Group)

Men felt that the helpline would need to clearly convey the nature of service on offer and any risks involved. These included both the public risks – entanglement with the legal system – and the private risks (judgemental attitudes).

Discussion of other sources of support also highlighted the importance of protecting men's private and public image. The non-judgemental and confidential nature of the GP–patient relationship was considered to encourage abusive men accessing this support. One participant described his GP as '*a stranger who you know*' (General Public Group 8). Similarly, the likelihood of disclosing abusive behaviour to friends or family members was seen to be determined by the extent to which a non-judgemental response could be anticipated. People in the workplace were unlikely to be identified as sources of support as the potential for damage to reputation and status was judged to be high.

Other problems identified with accessing help related to a general lack of confidence in formal services and knowledge about where perpetrators could seek help. Participants noted that services and campaigns were usually targeted at victims of domestic violence and often professionals did not know where to refer abusive men:

> *…a lot of GPs don't even know that these services exist …it's only through pushing you from pillar to post they might effectively make it…*
>
> (General Public Group 1)

Men's messages

Participants identified the importance of clear, non-conflicting campaign messages that avoided targeting specific populations. They referred to previous public education campaigns aimed at achieving a 'zero tolerance' of domestic violence and argued that the campaign needed to balance a non-judgemental stance with a perception of domestic violence as a crime:

> *The problem is you would encourage people to change or make it non-judgemental, the danger is that another sector of society will say how dare you say that, this is wrong.*
>
> (General Public Group 8)

Men participating in the BME group were clear that they would value seeing campaign posters in other languages:

> *Why don't you have the posters on buses in different languages? You never see that, they're always in English.*
>
> (BME Group)

However, participants in other groups were anxious about singling out particular groups:

> *…you'd have to be very careful 'cos you could offend.*
>
> (General Public Focus Group 7)

One group believed the message needed to portray domestic violence as unacceptable regardless of class or social status, whereas others felt the campaign might be more effective if it recognised the differences within the city:

> *– I think the thing that people have got to understand about Hull is it's not one city, it's a collection of villages which are all right next to each other…*
> *– There's loads of suburbs but it's all called Hull.*
>
> (General Public Group 2)

Participants conveyed a variety of imaginative suggestions for slogans and imagery for the campaign. 'Catchy' phrases suggesting that help was available were constructed:

> *Trapped, frustrated, out of control, angry….*
> *Let's talk about it*!
>
> (General Public Group 8)

> *We are not going to judge, just help.*
> *Get out before it's too late.*
> *It's not right but it's okay – we can help.*
> *Stop, look – we'll listen.*
>
> (General Public Group 3)

Other slogans tapped into the concept of a 'real man' whose strength is measured by his ability to recognise, and seek out help for his abusive behaviours:

> *Are you man enough to stop? Ask for help!*
>
> (General Public Group 8)

> *A real man can find a way to a better tomorrow for him and his family. Violence is not the answer*!
>
> (General Public Group 7)

The strength to change campaign and service

The formative research findings were used by a commercial advertising company to develop the social marketing campaign that was launched at a local football match and delivered twice in the city in 2009 and 2010. Considerable thought was given to the name of the campaign that also became the name of the new service for male perpetrators of domestic violence. 'Strength to Change' was selected to convey both masculinity and to emphasise change as a positive choice.

The campaign utilised a range of media as suggested by focus group members. Posters advertising the helpline and new service were displayed throughout the city in public locations such as bus stops and were concentrated in areas where domestic violence rates were known to be high. Focus group participants had highlighted how men listened to the local radio on their journey to and at work, and the campaign was also disseminated via this medium. A personal account published in the local newspaper by a man who had sought help to change his abusive behaviour was reported (via the helpline operatives) to have influenced men who subsequently contacted the new Strength to Change service. Other forms of dissemination included ambient media such as beer mats and wage slips of local government employees. Campaign material in the form of leaflets, posters for display and mugs were also targeted at relevant professionals such as GPs who would be likely to direct men to the service.

One of the key messages underpinning this campaign concerned men's self-reflection. This was chosen with the aim of prompting abusive men to reflect on and recognise their own destructive behaviours. The campaign poster shown below was designed to stimulate this process of self-reflection. It depicts a highly masculinised image but invites the viewer to interrogate that image. The juxtaposition of a man's private and public reputations is conveyed by the contrast between the visual image and the query raised about whether the public respect it commands is replicated in the setting of the family. The confidential nature of the service offered is emphasised and help-seeking is conceptualised as masculine 'strength' (Figure 1).

The Strength to Change service opened its doors in 2009. Men were required to self-refer via the helpline when a short screening tool was administered. Following this initial contact, men were invited to attend a face-to-face assessment session. Men considered to be suitable (eg, take responsibility for their behaviour, no underlying

https://doi.org/10.1017/S1463423612000473 Published online by Cambridge University Press

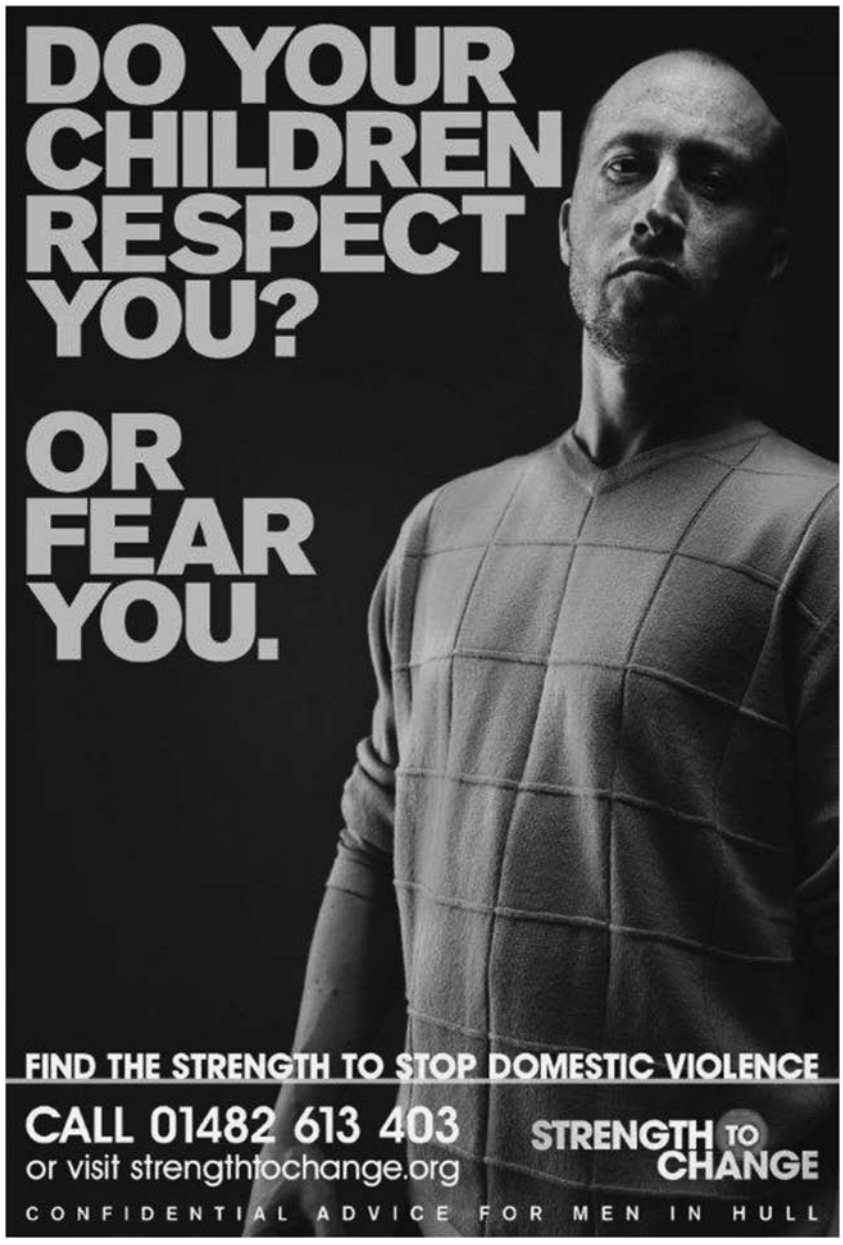

Figure 1 'Strength to Change' campaign poster

mental health condition) were offered 10 weekly 1 h sessions, followed by group work over 40 weeks. Advocacy and advice were also offered where appropriate (eg, housing, benefits). As the number of self-referrals received exceeded the capacity of the service, group relaxation sessions were introduced to manage the waiting list. In the first 18 months, 312 callers contacted the helpline, 210 of whom were perpetrators, resulting in 176 appointments (85%), with 78 (37%)

https://doi.org/10.1017/S1463423612000473 Published online by Cambridge University Press

completing an initial assessment. At the time of the evaluation of this service (Stanley *et al*., 2012b), 40 men had attended a group calming session and 51 had attended one or more of the perpetrator sessions.

Discussion

In this paper, we have reported how formative research with men in the general population was utilised within a social marketing campaign. Eliciting men's views on help-seeking generated the use of non-judgemental images that promoted the anonymous and confidential nature of the service.

This research confirmed that men would be reluctant to seek help if it was perceived to impinge on their masculinity. In addition, sensitivity around the topic of domestic violence also meant that men needed to overcome additional barriers of stigma, shame and embarrassment before they would access help. Through careful consultation and reflection of local perspectives, the Strength to Change campaign took into account the barriers that men face; it capitalised on men's masculinity and developed positive messages concerning help-seeking.

The limitations of this research include its location in one particular city. The use of focus groups, rather than anonymous methods of self-reporting may have inhibited more sensitive disclosures but the groups did appear to stimulate lively and creative discussion. Care was taken to recruit a wide range of men within the local area in terms of age, race and socio-economic status, as well as targeting those who had been and might be abusive.

Insights generated by this research support previous accounts describing the ways in which the social construction of masculinity can inhibit help-seeking (Galdas *et al*., 2005; Chan and Hayashi, 2010). The research also confirmed studies highlighting men's lack of trust in statutory services, concerns about confidentiality and lack of awareness as to how to access support (CSIP and NIMHE, 2006; Hester *et al*., 2006), as well as their aversion to judgemental attitudes and sole attribution of blame to perpetrators (Dobash *et al*., 2000; Cavanagh *et al*., 2001; Yamawaki, *et al*., 2012). The study findings are consistent with those informing the *Freedom from Fear* campaign (Donovan *et al*., 1999), which aimed to avoid a 'siege mentality', in addition to emphasising the consequences of abusive behaviour within the family unit and promoting the availability of help. Although many messages were considered in the course of the research, the campaign delivered in Hull promoted the understanding that violence is the responsibility of the perpetrator and not the victim, and that violence under any circumstance is not justified. The messages communicated were designed to encourage self-reflection while protecting the male image by depicting help-seeking as a strength rather than a weakness. These findings support those of O'Brien *et al*. (2005) who reported that men's reluctance to seek help could be understood in terms of a 'hierarchy to threats'; with help-seeking more quickly embraced when it was perceived as a means to *preserve* or *restore* another more valued enactment of masculinity

The emphasis on traditional images of masculinity in the campaign was consistent with the culture of a predominantly working class community characterised by high levels of deprivation. In this sense, the campaign mirrored the culturally specific attitudes, beliefs and values of its target population (Donovan and Vlais, 2005). One of the strengths of social marketing is the attention it pays to local context and culture and the formative research facilitated the delivery of culturally sensitive and salient messages contributing to positive take-up of the new Strength to Change service.

Conclusion

The research enabled the identification of barriers to help-seeking as well as messages that promoted self-reflection and protected cultural conceptions of masculinity in depicting help-seeking as a 'strength' rather than a weakness. This informed a campaign that generated a high demand for a local perpetrator service. The Strength to Change campaign located its target audience at the heart of the campaign's design, content and delivery. In this sense, the social marketing methodology acknowledges and utilises the expertise of those who use services in order to change behaviour.

Acknowledgement

This study was funded and supported by NHS Hull.

References

Andreason, A.R. 1995: *Marketing social change: changing behaviour to promote health, social development and the environment*. San Francisco, CA: Jossey-Bass.

Bagshaw, D., Chung, D., Couch, M., Lilburn, S. and **Wadham, B.** 2000: *Reshaping responses to domestic violence*. Commonwealth of Australia: University of South Australia.

Bonomi, A.E., Gangamma, R., Locke, C.R., Katafiasz, H. and **Martin, D.** 2011: ''Meet me at the hill where we used to park'': interpersonal processes associated with victim recantation. *Social Science and Medicine* 73, 1054–61.

Care Services Improvement Partnership and National Institute for Mental Health in England (CSIP and NIMHE). 2006: *Reaching out: evaluation of three mental health promotion pilots to reduce suicide amongst young men*. London: Department of Health.

Cavanagh, K., Dobash, R.E., Dobash, R. and **Lewis, R.** 2001: Remedial work: men's strategic responses to their violence against intimate female partners. *Sociology* 35, 695–714.

Chan, R. and **Hayashi, K.** 2010: Gender roles and help-seeking behavior promoting professional help among Japanese men. *Journal of Social Work* 10, 243–62.

Craig, M.E., Robyak, J., Torosian, E.J. and **Hummer, J.** 2006: A study of male veterans' beliefs toward domestic violence in a batterer's intervention program. *Journal of Interpersonal Violence* 21, 1111–128.

Department of Health. 2008: *What is social marketing?* London: Department of Health.

Dobash, R.E., Dobash, R.P., Cavangh, K. and **Lewis, R.** 2000: *Changing violent men*. Thousand Oaks, CA: Sage.

Donovan, R.J. and **Vlais, R.** 2005: *VicHealth review of communication components of social marketing/public education campaigns focused on violence against women*. Melbourne: Victorian Health Promotion Foundation.

Donovan, R.J., Paterson, D. and **Francas, M.** 1999: Targeting male perpetrators of intimate partner violence: Western Australia's "Freedom from Fear" Campaign. *Social Marketing Quarterly* V, 127–44.

Dutta-Bergman, M.J. 2003: A descriptive narrative of healthy eating: a social marketing approach using psychographics in conjunction with interpersonal, community, mass media and new media activities. *Health marketing quarterly* 20, 81–101.

Galdas, P.M., Cheater, F. and **Marshall, P.** 2005: Men and health help-seeking behaviour: literature review. *Journal of Advanced Nursing* 49, 616–23.

Gibbons, L., and **Paterson, D.** 2000: Freedom from Fear campaign against domestic violence: an innovative approach to reducing crime. Paper presented at the Conference Reducing Criminality, July 31 and August 1, 2000. Retrieved 31 July 2008 from www.aic.gov.au/conferences/criminality/gibbons.pdf

Gordon, R., MacKintosh, A.M. and **Moodie, C.** 2010: The impact of alcohol marketing on youth drinking behaviour: a two-stage cohort study. *Alcohol and Alcoholism* 45, 470–80.

Hester, M., Westmarland, N., Gangoli, G., Wilkinson, M., O'Kelly, C., Kent, A. and **Diamond, A.** 2006: *Domestic violence perpetrators: identifying needs to inform early intervention*. Bristol: University of Bristol in association with the Northern Rock Foundation and the Home Office.

Hunter, S. 2010: Context, background and rationale. In Robinson, L. and Hunter, S., editors, *Strength to change: developing and marketing a service to perpetrators of domestic violence in Hull*. (Ch 1) Hull: NHS Hull 14–35.

Levitt, H.M., Swanger, R.T. and **Butler, J.B.** 2008: Male perpetrators perspectives on intimate partner violence, religion and masculinity. *Sex Roles* 58, 435–48.

McKenzie-Mohr, D. 2000: Promoting sustainable behaviour: an introduction to community-based social marketing. *Journal of Social Issues* 56, 543–54.

Maclure, M., Frankham, J., Stark, S., Dean, C., and **Falola, G.** 2006: *Knowsley Young Men's Health Project (March 2005–March 2006)*. Summary compiled by Paula Cain – Knowsley Healthy Schools Manager. (Acquired through correspondence).

Mahalik, J.R., Good, G. and **Englar-Carlson, M.** 2003: Masculinity scripts, presenting concerns, and help seeking: implications for practice and training. *Professional Psychology: Research and Practice* 34, 123–31.

Mbilinyi, L., Zegree, J., Roffman, R.A., Walker, D., Neighbors, C.L. and **Edelson, J.** 2008: Development of a marketing campaign to recruit non-adjudicated and untreated abusive men for a brief telephone intervention. *Journal of Family Violence* 23, 343–51.

Moller-Leimkuhler, A.M. 2002: Barriers to help seeking by men: a review of socio-cultural and clinical literature with particular reference to depression. *Journal of Affective Disorders* 71, 1–9.

Montoya, J.A., Kent, C.K., Rotblatt, H., McCright, J., Kerndt, P.R. and **Klausner, J.D.** 2005: Social marketing campaign significantly associated with increases in syphilis testing among gay and bisexual men in San Francisco. *Sexually Transmitted Diseases* 32, 395–99.

National Social Marketing Centre. 2009: *Review of social marketing within public health regional settings*. London: National Social Marketing Centre.

O'Brien, R., Hunt, K. and **Hart, G.** 2005: 'It's caveman stuff but that is to a certain extent how guys still operate': men's accounts of masculinity and help seeking. *Social Science and Medicine* 61, 503–16.

Pavlou, M. and **Knowles, A.** 2001: Domestic violence: attributions, recommended punishments and reporting behaviour related to provocation by the victim. *Psychiatry, Psychology and Law* 8, 76–85.

Potter, S.J. and **Stapleton, J.G.** 2011: Bringing in the target audience in bystander social marketing materials for communities: suggestions for practitioners. *Violence Against Women* 17, 797–812.

Quinn, G.P., Bell-Ellison, B.A., Loomis, W. and **Tucci, M.** 2007: Adolescent perceptions of violence: formative

research findings from a social marketing campaign to reduce violence among middle school youth. *Public Health* 121, 357–66.

Stanley, N., Fell, B., Miller, P., Thomson, G. and **Watson, J.** forthcoming 2012a: Men's talk: exploring men's understandings of violence against women and motivations for change. *Violence against Women*.

Stanley, N., Graham-Kevan, N. and **Borthwick, R.** 2012b: Fathers and Domestic Violence – building motivation for change through perpetrator programmes. *Child Abuse Review* 21, 4, 264–74.

White, A. 2006: Men and mental wellbeing – encouraging gender sensitivity. *The Mental Health Review* 11, 3–6.

White, A. and **Banks, I.** 2008: Men and help seeking. In Kirby R., editor, *Men's Health*, Third edition. London: Martin Dunitz and Parthenon Publishing.

White, A.K. and **Johnson, M.** 2000: Men making sense of their chest pain – niggles, doubts and denials. *Journal of Clinical Nursing* 9, 534–41.

Winstok, Z., Eisikovits, Z. and **Gelles, R.** 2002: Structure and dynamics of escalation from the batterer's perspective. Families in society. *The Journal of Contemporary Human Services* 83, 129–41.

World Health Organisation 2007: *Primary prevention of intimate-partner violence and sexual violence: background paper for WHO expert meeting (May 2–3 2007)*. Geneva: World Health Organisation.

Yamawaki, N., Ochoa-Shipp, M., Pulsipher, C., Harlow, A. and **Swinder, S.** 2012: Perceptions of domestic violence: the effects of domestic violence myths, victim's relationship with her abuser, and the decision to return to her abuser. *Journal of Interpersonal Violence*, doi. 0886260512441253.