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Breaking the Silence Surrounding Hepatitis C by Promoting Self-Efficacy: A Study of Hepatitis C Public Service Announcements

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Abstract

Hepatitis C (HCV) is the most common chronic blood borne virus in the United States. Despite this fact, there is a startling lack of awareness about HCV among individuals who may have contracted the virus. This study, grounded in self-efficacy theory, analyzes public service announcements (PSAs) for HCV. Using focus groups to contextualize the responses of individuals living with HCV, the authors conclude that stigma and structural barriers pose the greatest challenges for health communicators trying to reach at-risk populations. The findings suggest that expanded use of celebrity appeals, realistic drug portrayals, more extensive use of social networking in tandem with non-traditional media, and tapping into veterans, while minimizing fear tactics and maximizing self-efficacy messages, offer new hope for successful health communication strategies. With 3.9 million people in the United States infected with HCV, this study offers urgently needed communications strategies to address this silent epidemic.

Key words: public service announcements; hepatitis C; self-efficacy; stigma

Hepatitis C (HCV) is “the most common chronic blood borne virus infection in the United States” (Buffington, Rowel, Hinman, Sharp, & Choi, 2001, p. 47). However, there is a startling lack of awareness about HCV among individuals who may have the virus (Buffington et

al., 2001; Parini, 2001), making this disease a silent epidemic that necessitates breaking the silence surrounding HCV to improve public health. To that end, this study, grounded in self-efficacy theory, addresses public service announcements (PSAs) concerning HCV while offering insights into strategic communication strategies to address this burgeoning epidemic.

Contextualizing the Study

Hepatitis C is a liver disease caused by the hepatitis C virus that is found in the blood of infected individuals. The two most common ways of contracting the disease are contact with blood, blood products, or solid organs from a donor whose blood contained HCV or through sharing needles; health care work, tattoo creation/inking, and sexual contact can also be factors in transmission. According to the Centers for Disease Control and Prevention (CDC), HCV will soon reach epidemic proportions (CDC, 2006). In the United States, “3.9 million people...were infected, four times the number infected with HIV” (Wong, McQuillan, Hutchison, & Poynard, 2000, p. 1562). Considering the high infection rates, diagnosis and treatment are still limited (CDC, 2006; Instone, Gilbert, & Mueller, 2003; Wong et al., 2000). Despite these facts, there is a startling lack of awareness about HCV among individuals who may have contracted the virus, which has the potential for decreased overall personal health, increased transmission rates, and the expenditure of millions of dollars in health care costs (Buffington et al., 2001; Parini, 2001; CDC, 2006; Wong et al., 2000). Therefore, the lack of awareness about HCV makes this disease a silent epidemic, making this study an important contribution to health communication.

Theoretical Underpinning

Changing health-related behaviors is extremely challenging, whether it involves attempting to persuade the audience to adopt new behaviors or to stop harmful ones. Bandura’s (1997) work suggests that health messages that include coping strategies within the content of the message itself may promote the viewer’s self-efficacy or the viewers’ perception of his or her

own personal capacity for change. Self-efficacy might best be defined as an individual's assessment of his or her ability to cope with health-related circumstances, the potential ramifications of those circumstances, and the subsequent ability to act upon that knowledge (Fry & Prentice-Dunn, 2005). Self-efficacy suggests that the assessment of potential threats and coping resources is predicated on maximizing personal benefits.

Bull, Holt, Kreuter, Clark, and Scharff (2001) studied communication variables and their impact on communication outcomes, specifically focusing on changing health behaviors. The results of their study revealed an important preliminary step in facilitating behavioral change, specifically that individuals must like, attend to, and understand the health information presented (Bull et al., 2001). Public service announcements (PSAs), a broadcast medium that can relay health information, must contain relevant material and individuals must feel an affinity for the manner in which the message is presented before they will consider changing their behavior. In short, PSAs must be resonant. The preliminary steps of liking the message and perceiving it as relevant can be achieved by presenting information in ways that are attractive, informative, encouraging, new, and useful (Bull et al., 2001). Therefore, PSAs have the potential to not just tell people the "right" way to behave, but also provide practical suggestions based on the audience's lifestyle (Bull et al., 2001). Thus, in order to encourage adoption, use, and maintenance of new behaviors PSAs must be likeable and resonant, based on the audience's lifestyle (Bull et al. 2001), offering tangible coping strategies (Fry & Prentice-Dunn, 2005).

Stigma and Barriers to Testing

To successfully engage at-risk populations, health communicators must also examine the stigmas and structural barriers that may impede prevention, testing, and treatment. Currently, there is little research in the available communication literature related to HCV. However, literature on HIV/AIDS—another blood-borne, communicable viral disease—suggests that

stigma is a significant factor. For the purposes of this study, stigma is defined as negative external judgments based on a person's presumed health condition and/or social standing. As seen in the HIV/AIDS literature, stigma is often a significant factor for individuals with communicable diseases.

Research on high-sensation seeking individuals suggests that empathetic messages that stimulate self-efficacy are helpful in promoting disease prevention (Campbell & Babrow, 2004; Fry & Prentice-Dunn, 2005; Noar, Zimmerman, Palmgreen, Lustria & Horosewski 2006; Perse, Nathanson & McLeod, 1996). Yet, self-efficacy alone is not enough to combat or outweigh stigma, as it is a powerfully demotivating factor. Consider a 2000 Internet survey that found that one in five respondents agreed that people who contract communicable diseases are typically drug users and "have gotten what they deserve" (Valdiserri, p. 341, 2002). At-risk individuals sense these judgments; additionally, they often fear judgments about their perceived or actual sexual and drug behaviors from the medical providers administering tests (Singer, Stopka, Siano, Springer, Barton, Khoshnood, Gorry de Puga & Heimer, 2000; Valdiserri, 2002). Therefore, such judgments keep at-risk individuals from getting tested. Similarly, stigma can also discourage at-risk individuals who have experienced non-drug related events from seeking treatment (Singer et al., 2000). Further, individuals with non-drug related infections comprise a substantial portion of the HCV population (Buffington, et al., 2001; Wong et al., 2000).

The literature suggests that the use of celebrities has potentially positive effects (Brown & Basil, 1995; Casey, Allen, Emmers-Sommer, Sahlstein, DeGooyer, Winters, Wagner, & Dun, 2003; Hollander, 1993; Kalichman & Hunter, 1992). When Los Angeles Lakers' basketball star "Magic" Johnson announced that he was HIV positive, there was a strong degree of emotional involvement with him due to his celebrity status, increasing the concern about AIDS among individuals who identified with him (Brown & Basil, 1995).

Beyond stigma, there are structural barriers that are only exacerbated by the stigma surrounding communicable diseases (Bond, Lauby, & Batson, 2005; Campbell & Babrow, 2004; DeJong, Wolf, & Austin, 2001). Structural barriers include a lack of information or the dissemination of misinformation, inadequate access to health care, and the lack of a primary health care provider (Bond et al., 2005; Gasiorowicz et al., 2006; Wong et al., 2000). Furthermore, people without a primary care provider are much less likely to get tested for HIV and HCV (Bond et al., 2005; Gasiorowicz et al., 2006). Additionally, the literature also suggests that fear appeals, which can exacerbate stigma and strengthen barriers, can have unintended negative effects such as discouraging those in the pre-contemplation stage from getting tested (Cho & Salmon, 2006). Together, stigma and structural barriers pose significant challenges to health communicators.

It is clear that HCV health communication, including PSAs, cannot just encourage at-risk individuals to seek testing and treatment by employing adoption, use, and maintenance strategies (Bandura, 1997); rather, they must first address the barriers and stigmas to getting tested.

Research Questions

It is clear that messages addressing stigma and structural barriers are imperative for successful communication about prevention, testing, and treatment of HCV while promoting self-efficacy. Individuals at risk for HCV must find likable resonance (Bull et al., 2001) and tangible coping strategies (Fry & Prentice-Dunn, 2005) within the messages if health communicators hope to encourage adoption, use, and maintenance of new health-related behaviors (Bandura, 1997). Despite HCV's near epidemic status (Buffington et al., 2001; Wong et al., 2000), there have been few, if any, studies analyzing health communication messages and individuals' responses to these messages. Therefore, two broad research questions frame this study:

RQ1: How do individuals with HCV interpret the messages within HCV PSAs?

RQ2: What kinds of messages might this target audience find most resonant and why?

The research questions are broad by design to offer opportunities for more fluid discussions emanating from the personal experiences of living with HCV, rather than focusing primarily on the PSA texts. A more fluid interplay between personal experiences and the text offers opportunities to elicit thicker descriptions (Denzin, 1998) and encourage experience-based, interpretive responses on the part of the participants, thus leading to richer analytic interpretations. This complies with Denzin's (1998) argument that "good interpretation takes us into the center of experiences being described" (p. 316).

Method

When conducting health-related research on at-risk populations, significant procedural issues arise. First, there is the issue of access to patients, which is even more problematic when addressing a population with a communicable disease. With the Health Insurance Portability and Accountability Act of 1996 (HIPAA), gaining access to patients can be an especially difficult proposition. Second, there are the issues of confidentiality and trust, as these are significant issues among any patient populations (Fontana & Fry, 1998). However, for a patient population with HCV, a stigmatizing communicable disease, confidentiality and trust become even more salient (Singer et al., 2000). Cognizant of these issues, the authors chose focus groups, drawn from existing statewide HCV support groups, to gain the appropriate sample for this study. Existing support groups provided access to the HCV target population while remaining in compliance with HIPAA. By working closely with the facilitators of each support group, the trust level among potential focus group participants grew, increasing confidentiality while ensuring the likelihood of fruitful responses. Finally, the principal investigator's (PI) self-disclosure of living with HCV potentially deepened the trust developed with the participants, eliciting more candid disclosure.

Participants

Participants were drawn from three Wisconsin HCV support groups, which represents all of the support groups across the state. Participation was solicited by an electronic flyer (with a printable version) and distributed by the support group facilitators during spring 2005. Participants were offered a \$30 participation fee. The focus groups ranged from five to nine participants with a total of 21 participants; all but three, who were family members, had HCV. The Fox Valley HCV Support Group (Appleton, Wisconsin) had five participants. All were Caucasian males and ranged from ages 46 to 57 with one man on disability, one was unemployed, two worked in non-skilled jobs, and one was a professional. The University of Wisconsin Medical Center HCV Support Group (Madison, Wisconsin) had nine participants. Four were male and five were female and ranged from ages 38 to 71 with one who was retired, one unemployed, five were professionals, and two worked in technical jobs. Six were Caucasian, one was African American, one was of mixed ethnicity, and one was Native American. The Medical College of Wisconsin HCV Support Group (Milwaukee, Wisconsin) had seven participants. Four were male and three were female and ranged from ages 23 to 53. Two were unemployed, three worked in skilled trades, one was a homemaker, and one was in sales. Five were Caucasian and two were Native American.

Procedure

Focus groups were conducted on site in private conference rooms during June and July 2005. To enhance trust (Fontana & Fry, 1998; Singer et al., 2000), support group facilitators were present but did not participate. Each session lasted approximately 90 minutes and was led by the PI. Each session began with an introduction of the study, along with the PI's personal disclosure of having HCV, which also potentially increased trust (Fontana & Fry, 1998; Singer et al., 2000). The PI then obtained written permission from each participant, paid the participation fees, and collected basic demographic data in the form of a written survey. This was completed

in approximately 15 minutes. During the next 15 minutes, participants were asked icebreaker questions about their experience living with HCV and reasons for getting tested or barriers they had experienced. Following this introductory discussion, four PSAs (produced by the Texas Department of Public Health and provided to the PI by the CDC) were shown. Each was shown twice and was played again if requested by a participant. Research questions were then put forth to the group. This discussion period lasted approximately 60 minutes. All focus group sessions were tape-recorded and tapes were transcribed immediately following each session. The protocol was approved by the University's Institutional Review Board prior to commencing the study.

Instrument

The discussion was structured around research questions designed to establish trust and break the ice while eliciting in-depth, personal responses. The first set of questions consisted of icebreakers (e.g. "Can you share a little about your life—your experiences living with HCV?" and "Why did you choose to get tested for hepatitis C?" and "Can you tell me some of the specific reasons you got tested or barriers that slowed down that decision?"). Discussion of the responses lasted approximately 15 minutes, as each individual was allowed time to share their experiences and opinions. Participants were then shown the PSAs and asked a second set of open-ended questions about their response to the content of the PSAs (e.g. "Which of the spots did you like best and why?" and "How did they make you feel and why?" and "What did you see as the main idea of each?"). They were encouraged to link their personal stories of living with HCV to the discussion questions. The session ended with closing questions (e.g. "Do you have any further insights on your experiences with Hep C?" and "Do you have any other suggestions that you'd like to share?"). These research questions led to generally animated discussions, with the PI soliciting responses from quieter participants and gently quieting more dominant participants (Krueger & Casey, 2000).

Textual Summary

To contextualize the findings, it is imperative to introduce a brief textual analysis of the PSAs to which the participants responded. Both PSAs take differing approaches, with the 30-second spots briefly sketched below. In both cases, there was also a corresponding, abbreviated 10-second PSAs for a total of four PSAs. For clarity, each is referenced using italics.

Freddy Fender is a documentary style PSA in which Hispanic singer/songwriter Freddy Fender—now deceased, but alive at the time this research was conducted—sits forthrightly on a stage with his guitar in hand and introduces himself. He candidly discusses his personal experiences with HCV and encourages testing, stating that “Hepatitis C destroys the liver and more than 300,000 Texans may have it and don’t know it.” He goes on to state that “there is hope,” while a 1-800 telephone number appears on the screen. He then states that there is treatment and “it will help you live better.” The spot closes with Fender saying, “If you had a blood transfusion before ’92 or shared needles, get tested!”

Dart Thrower follows a more dramatic format. The PSA opens as a cape whirling “dart thrower” takes aim at a clean-cut young boy strapped to a spinning dart board. Both are African American. Needles—used as darts—are hurled at the young boy as a dramatic voiceover states, “Welcome to Hepatitis C. It can cause liver cancer and a slow, painful death.” The sound effects and environment are ominous, as the camera pans across urban youths displaying at-risk behaviors such as drug use and tattooing. The hushed voiceover goes on to say, “You can catch HCV from sharing needle or street tattoos.” Again, the 1-800 telephone number appears on the screen with the tagline, “Don’t get stuck with Hepatitis C.” The voiceover concludes with “Don’t do it because one slip can result in a lifetime of regret” while a needle hits the boy’s arm. The spot closes with the tagline and an informational 1-800 number superimposed on the screen, while a needle lands at the bottom as if to underline the message.

Data Analysis

Following procedures outlined in Denzin (1998) and supported by Krueger and Casey (2000), the PI and co-investigator, working independently, reviewed all the transcribed comments. Working under the guiding principles that texts are translated through the audience and that personal stories can offer salient insights (Denzin, 1998), the authors reviewed the transcribed comments multiples times identifying common themes that emerged from the focus groups. After individual analysis that focused on the “interpretation as storytelling” (Denzin, 1998, p. 317), the co-authors then shared their thematic interpretations and correlated them to the research questions. This layered, interpretive style permitted a systematic cross-referencing of themes as well as allowing for thick descriptions (Denzin, 1998). In the results and conclusion, participants are identified only by their first name to protect their anonymity.

Results

Having analyzed the data, it is clear that the two research questions did indeed provide fluid interplay between personal experiences and the text analyzed, eliciting thick descriptions through storytelling (Denzin, 1998). The analysis, taking the co-authors “into the center of experiences being described” (Denzin, 1998, p. 316), suggests three thematic categories: effects of stigma, barrier to testing and treatment, and future opportunities. These three categorical findings illustrated how the participants in this study interpreted the messages within the PSAs. They also highlighted the types of messages that are resonant as well as those that were ineffectual. The findings, as they emerged from the research questions, also suggested new opportunities for health communicators addressing this silent epidemic.

Effects of Stigma

After viewing the PSAs, the participants were given the opportunity to respond to the spots. “The bottom line is I don’t want the stigma,” Morris said. Stigma is, indeed, a huge issue

for the participants in this study—it was the overriding concern in every focus group, with every person, without exception. “I’m afraid that I need to be selective because right away they say, ‘you’re a drug addict.’ It may not have been that,” Darren said. “You worry about telling people because right away, it’s always drugs,” Morris added. They experienced stigma within the medical community, within their families, and across the greater social community.

Stigma is most pronounced within the larger social community and *Dart Thrower* brought these experiences to the surface. “It looks like these people (in the PSA) are a bunch of low-lives. Like they’re all hiding away in the streets. It’s not always that. A businessman might be up in his office shooting up,” John said. Michael’s word supported that reaction and expressed a frustration about the lack of portrayals of drug use among “other” people or other ways of contracting HCV. “There’s that sigma of having it (HCV)...I think there’s a value judgment in the *Dart Thrower* one. It felt like if I were of color, I would—well it’s judgmental,” Michael said. Brett characterized the spot as “very jarring, underworld—a black (dark) clutter. The types of stigmas that are already associated with drug use were certainly played out.”

One participant, JJ, summarized many of the group members’ unease about the *Dart Thrower* ad:

The problem I have with it [is that] there are a lot of ways to get Hep C and they only focused on people who used. And, even though I’m one of those people, I know a ton of people who never did and don’t have a clue how they got it (HCV). I’m thinking these PSAs may end up creating a stigma for individuals that have Hep C. They won’t even go for the treatment because they don’t want to be caught with that stigma.

Not a single individual was comfortable with *Dart Thrower*, no matter how they contracted HCV, and regardless of their ethnicity, age, and gender. Furthermore, not a single individual found it likeable. Without likable resonance, stigmatization becomes more

pronounced, repelling participants rather than drawing them in and engaging them with the potential for adopting, using, and maintaining new behaviors (Bull et al., 2001; Bandura, 1997).

Freddy Fender, on the other hand, appears to be highly “likable” (Bull et al., 2001) precisely because it did not feel stigmatizing. “The spot offers hope,” Beth said and suggested that Fender was someone she felt she could trust. “If you see Freddy, he’s been doing it and he’s getting better... You don’t have to be a bad person to get Hep C,” Michael added. These statements, along with many others, articulate that the individuals in this study often perceive themselves as being viewed as “bad” people because of their HCV status. The shame attached to the pervasive stigma was clearly a central theme. For the participants, the *Freddy Fender* spot expressed “tangible” coping strategies (Fry & Prentice-Dunn, 2005) without shaming the audience. Michael said, “I liked the personal account and his high profile. He was encouraging, not shaming.” Brett said, “It’s just a virus. It’s not a dark, dirty, dingy lifestyle that brings it on.” The idea that “it’s just a virus” was repeated multiple times as participants expressed their frustration with shaming, while sharing positive responses to the *Freddy Fender* spot. The participants overwhelmingly associated the *Freddy Fender* spot with positive feelings that blunted negative stereotypes and offered hope; such positive, empathetic messages have previously been demonstrated as increasing self-efficacy (Campbell & Babrow, 2004; Fry & Prentice-Dunn, 2005; Noar et al., 2006; Perse et al., 1996).

The participants also discussed the desire for more concrete information. “You gotta see the proof,” Mary said. Darren added, “Why don’t they show the HIV numbers and then the HCV numbers?” Darren clearly knew that there are more individuals with HCV than with HIV. Darren's comment, along with other similar comments, highlighted that this group of individuals with HCV was highly informed. The *Freddy Fender* spot fulfilled the participants’ need for

tangible information by promoting self-efficacy with tangible messages of hope, which have been demonstrated to reduce health threats (Fry & Prentice-Dunn, 2005). Empathetic messages on the whole stimulate self-efficacy and promote disease prevention (Campbell & Babrow 2004; Fry & Prentice-Dunn, 2005; Noar et al., 2006; Perse et al., 1996). In the end, the participants' reactions to *Freddy Fender* suggest that the hopeful, affirmative, informative, and non-shaming messages will produce a greater likelihood of adopting, using, and maintaining new health-related behaviors (Bandura, 1997).

Barriers to Testing and Treatment

There are three main barriers to testing and treatment that emerged from this study: misinformed health care providers; generalized fear on the part of individuals who are, or may be, infected with HCV; and the lack of information about HCV. Health care providers are the gatekeepers of healthcare. Thus, their influence is substantial (Bond et al., 2005; Campbell & Babrow, 2004; Gasiorowicz et al., 2006). The experiences of the participants in this study indicate that, on occasion, health care providers, particularly general practice providers in smaller communities, are ill informed about HCV and the treatment protocol. "One barrier I did see was the nurse...she said, 'just let it take its course,'" Mark said. John added, "my local doctor said the same thing and I said, 'no way buddy, I want to be treated.'"

Fear, as a theme, wove itself throughout all three focus groups. Individuals fear lack of health care support in addition to fearing the stigma of others knowing they have HCV, as previous discussed. They fear their future with HCV. "It's like cigarette smoking, you don't see the effect, so you don't act on it right away," Darren said. They fear the treatment process. "The medicine makes you more depressed," Peter said. Overall, without empathetic messages, addressing fear and stimulating their predisposition to self-efficacy; prevention, testing, and treatment becomes increasingly difficult (Campbell & Babrow, 2004; Fry & Prentice-Dunn,

2005; Noar et al., 2006; Perse et al., 1996). It is evident that fear tactics are unacceptable to these individuals; in fact, fear tactics repel them. Responding to *Dart Thrower*, Jeanne said, “It’s too violent, it’s got too much of an edge.” “I didn’t like that one, it was too scary,” Beth said. The threatening voice-over didn’t help the spot. “I don’t want to hear about a slow, painful death,” Frank said. Furthermore, the fear appeals used in *Dart Thrower* appeared to cause disassociation. “I’m nothing like them,” commented JJ. This disassociation supports the findings of Bull et al. (2001) and further suggests the importance of ads having likeability or resonance. Ultimately, the fear appeals used in *Dart Thrower* appear to exacerbate stigma and strengthen barriers, having unintended negative effects as also demonstrated in the Cho & Salmon (2006) study.

Lack of information is also a barrier. Most participants had a strong desire to know facts. Participants were drawn to the statistics in the *Freddy Fender* spot. “I think if you showed numbers, people would be shocked,” Darren said. Participants wanted information. “The longer *Freddy Fender* one is good because there were numbers. That’s important. People are unaware that the numbers are growing. People need to know about the many ways you can get it, not just drugs,” Frank said. In addition, tangible information mattered to the individuals in this study. Information provides hope and offers tangible means of coping (Fry & Prentice-Dunn, 2005). As Julie stated, “Knowledge is supposed to be power. We need to get some knowledge out there.”

Future Opportunities

Considering the need to “get some knowledge out there,” as Julie stated, the authors now turn to four opportunity themes that emerged this analysis: expanded use of celebrities, realistic drug portrayals, more extensive use of social networking in tandem with non-traditional media, and tapping into veterans.

The responses of participants illuminate the power of celebrity. “I like the *Freddy Fender* one...I like the personal account and his high profile. He was encouraging not shaming,”

Michael said. Taking this idea deeper, Beth stated:

I found the *Freddy Fender* one interesting. It think it reflects how I’m still feeling my way through this, without getting so much information that I just let my emotional self—well, I just kind of take myself with me as I go. I’m looking and reading a lot and finding encouragement when I read personal accounts where people aren’t anonymous. There they are, high profile or public figures. They’re living with this and I’m thinking I can do that too. It’s encouraging to me to hear someone tell their story that’s a high profile person and doesn’t feel bad. It doesn’t have that sense of shame that (makes) so many want to keep their anonymity.

“The *Freddy Fender* ad hit home,” John said. “Hitting home” created a lot of discussion about the use of celebrities generally, suggesting enhanced self-efficacy through celebrity modeling. A number of individuals spoke of using singer/songwriter David Crosby or even “writing a song about it (HCV)” Mark said.

However, the results demonstrate that celebrity alone is not enough. There needs to be specific actions that lead to positive outcomes (Brown & Basil, 1995; Hollander, 1993; Kalichman & Hunter, 1992). “I think showing success is crucial. Like Naomi Judd living with it and sharing about it and she’s cured. Just show some success,” John G. said. The celebrity theme was highly resonant across all three focus groups, with individuals expressing the need for someone who is well-known, who feels “real,” who has HCV and is successfully dealing with it, and who is trustworthy. Providing hope through empathic messages matters greatly (Campbell & Babrow, 2004; Fry & Prentice-Dunn, 2005; Noar et al., 2006; Perse et al., 1996). As demonstrated here and by others (Brown & Basil, 1995; Casey et al., 2003; Hollander, 1993; Kalichman & Hunter, 1992), employing a strong celebrity appeal using someone delivering hopeful and resonant message offers strategic communication alternatives. After all “real people have Hep C,” Diane said.

The responses of recovering addicts highlight a significant finding: the need for realistic drug-use portrayals. With few exceptions, the participants saw *Dart Thrower* as unrealistic. Without realistic portrayals, empathy will be limited as well as the ability to stimulate self-efficacy (Campbell & Babrow, 2004; Fry & Prentice-Dunn, 2005; Noar et al., 2006; Perse et al., 1996). Paul, rather ironically, expressed the lack of realism, “It would probably be better to use needles like people really use, not these big honking things. What drug addicts do you see ever using a needle like that? I never did (laughter). Put real needles in there (more laughter).” Dave added, “With the guy on the wheel (laughs) why not get horse needles and use them like spears (laughter).” The group went on to ironically joke about their past using and HCV.

The participants’ comments strongly suggested that fear tactics would be ineffective. “My drug dealer never told me the risks that were involved (huge barrage of laughter). He was pretty insensitive. I never heard anything about this Hep C when I was shooting up,” Peter added in an ironic tone. The thick descriptions of these recovering addicts suggest that *Dart Thrower* would not successfully engage active drug users or recovered addicts, and surely not non-users, in adopting new self-efficacy behaviors (Bandura, 1997). To reach at-risk addicts or those in recovery, the first step, resonant likeability (Bull et al., 2001), necessitates the use of people in recovery as production consultants to ensure realistic portrayals. Fear tactics alone are simply not effective (Cho & Salmon, 2006).

Discussion

The research objectives of this study were to examine how individuals with HCV interpret the messages and what kind of messages this audience may find resonant. Self-efficacy appears to be at the heart of the interpretive process and thus the use of self-efficacy models can enhance strategic health communication. Further, the findings offer health communicators

specific insights into how to create more resonant messages and thus more successful reach individuals infected with HCV.

The findings emerge from a layered analytic approach, enhanced by techniques to deepen trust (Fontana & Fry, 1998; Singer et al., 2000) and elicit thick descriptions (Denzin, 1998). The results demonstrate the strengths of using empathic, information-based self-efficacy messages (Campbell & Babrow, 2004; Fry & Prentice-Dunn, 2005; Noar, et al., 2006; Perse et al., 1996) to promote testing for and treatment of HCV. They also reveal the power of likeable messages that reflect the target audiences' experiences and lifestyle (Bull et al., 2001). Furthermore, the findings illustrate that stigma and structural barriers pose the greatest threat to testing, and thus it is imperative for health communicators to address stigma and barriers in tandem with creating self-efficacy messages. Additionally, this study demonstrates that fear tactics exacerbate stigma and strengthen barriers, often having unintended negative effects (Cho & Salmon, 2006). On the other hand, the findings conclude that celebrity appeals offer great opportunity to foster the adoption, use, and maintenance of new health-related behaviors through self-efficacy (Bandura, 1997).

The results of this study demonstrate the importance of tangible, empathic messages while avoiding fear tactics. The results further illustrate the powerfully negative effects of stigma, bearing out the importance of non-judgmental messages that can neutralize stigma (Singer et al., 2000; Valdiserri, 2002). The participants specifically confirmed three barriers to testing and treatments: misinformed health care providers; generalized fear on the part of individuals who are, or may be, infected with HCV; and the lack of information about HCV. Additionally, the results offer four alternative communication opportunities: expanded use of celebrities, realistic drug portrayals, more extensive use of social networking in tandem with

non-traditional media, and tapping into veterans. Ultimately, the participants' strong positive response to the *Freddy Fender* PSA and equally strong negative reaction to *Dart Thrower* exemplifies the power of celebrity, along with strong negative reactions to fear tactics, a longing for realistic portrayals, and an intense desire for information.

In the end, there are few, if any, communication-based studies on HCV. However, epidemiology studies on HCV suggest that the virus is at near-epidemic proportions and that a lack of awareness about HCV among individuals who may have the virus poses a significant problem for public health officials across the United States (Buffington et al., 2001; Parini, 2001; Wong, et al., 2000). Utilizing the findings of this study, which are framed within self-efficacy theory, health communicators have the potential to develop resonant and highly effective health communication campaigns.

Limitations and Future Research

One limitation of this study was the use of PSAs produced in Texas in Wisconsin focus groups. This may have reduced resonance as the PSAs were produced for a different geographic target audience. A second limitation is the recent death of Freddy Fender, which prohibits this study from being effectively replicated. In terms of future research, given the strong indication that social networking is actively used among these individuals as they learn to cope with their illness, the authors suggest that a study exploring social networking among individuals with HCV may be worth pursuing in future research. Furthermore, this study exemplifies a single unique factor in building trust with at-risk individuals (Fontana & Fry, 1998; Singer et al., 2000): the PI's willingness to disclose personal experiences with HCV. Considering the richness that this disclosure added to the findings, the authors suggest that future studies consider the benefit of self-disclosure of related personal health conditions as a means of accessing deeper levels of

trust and ultimately eliciting richer findings. Considering the richness of the discussion, testing of future HCV PSAs would benefit from the input of people living with the disease.

Conclusion

What emerges from this study is a poignant picture of individuals living with HCV, while demonstrating a tremendous level of self-efficacy. This high level of personal self-efficacy suggests that PSAs strategically structured around self-efficacy communication models would be highly effective in reaching the larger audience of individuals at risk for HCV (Bandura, 1997; Bull et al., 2001; Campbell & Babrow, 2004; Fry & Prentice-Dunn, 2005; Noar et al, 2006; Perse et al., 1996). Considering that millions of American are infected with HCV, a far great number than those infected with HIV (Wong et al., 2000), the findings of this study propose that swift and strategic communication is imperative to stimulate the adoption, use, and maintenance of new health-related behaviors (Bandura, 1997). Decisive communicative action will lead to successful testing for and treatment of HCV. This study offers compelling evidence encouraging health communicators to join together and offer definitive actions to break the silence surrounding this burgeoning epidemic.

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