Trimming the Fat: How Advertising Can Better Approach the Obesity Problem

A Senior Honors Thesis

by

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Abstract

Recently, obesity has emerged as the number one social ill of Americans, just as it soon will surface as the number one cause of preventable death. It's become the topic of the day. However, all of the activist and media commotion has had little impact on the general trend affecting our country. People, while exposed to commercial messages about inactivity and overeating, lack the motivation to change their behavior. Advertising can play an important role in motivating societal change. Examination of the obesity problem and past public service advertising, behavior change models, and effective message development create opportunities for society to be better served by public service marketing efforts, both in general and specifically concerning obesity.
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Trimming the Fat: How Advertising Can Better Approach the Obesity Problem

INTRODUCTION

It’s the question of the hour – how can Americans be so unconcerned about their weight? Research is telling us that overeating and inactivity are having more of an effect now than ever before, and the effects of obesity are proving to be more and more deadly. At the same time, our media screams at us constantly about the newest weight loss products and plans. So why aren’t we listening?

I propose that it’s our culture – built around the use of food as a social, emotional, and entertainment crutch. As a country built of immigrants with traditions of their own, many based in feasting and food preparation, we’ve built entire holidays around the premise of eating until we must waddle away from the dinner table. NBC’s Mr. Food says it best - “Ooh, it’s so good!”

Certainly not everyone suffers because of this food culture, but some of us are hereditarily predisposed to being what is politely called “big boned.” Combine this DNA with the culture that places camaraderie and comfort in the same context as a big plop of mashed potatoes and gravy, and a national epidemic becomes a little more understandable.

We eat because we like it! It tastes good! It makes us feel warm and fuzzy inside! It’s where we came from – we just have to honor grandma by making (and EATING!) that pecan pie!
And while all of those messages from Weight Watchers and Dr. Atkins are flying at us from every direction, those of us that really get pure enjoyment from consumption of food find little motivation to change. The pleasure we get from eating cannot possibly outweigh the pleasure we'd get from losing our extra pounds. We are letting ourselves believe that eating that juicy steak or extra helping of buttered biscuits is worth more than our lives. In other words, the health benefits we would see from being lighter and healthier is not worth the pain of not eating what we want, as much as we want and when we want it.

On the other side of the coin, life in the United States continues to reach new plateaus in the age of convenience. We don't even have to push the buttons on the VCR to record a show anymore - TiVo does it for us. So much for turning the key in the lock - a finger touch pad or remote control lets us right in. Why walk the dog when you've got a whole fenced-in lawn for him to run around in?

And work seems to be more demanding than ever - who can find time to exercise when you've got twelve hours of work to fit into an eight hour day? Not to mention the family and social obligations that sit, waiting at home. In fact, some people don't even have to leave their desk chair to chat with the neighbors or stop by the grocery store on their way home - the internet has revolutionized the way we do just about everything.

An increased appetite for a fulfilling meal and a decrease in even the simplest exercise we get every day has combined to create the massive monster we call "the obesity problem."

Boiled down, it's a sincere lack of logical, emotional and functional motivation.
Advertising

Every day we are exposed to thousands of messages. Advertisements scream for us to try the latest product, visit the new and improved location, and to take advantage of "No Money Down!" They attempt to convince us to change our preferences, habits and beliefs. They attempt to motivate us to effect change within our lives, each on a different level and playing field.

So why can't these motivating messages help us get motivated to work towards living more healthily? Simply put, they have the potential, but no one has taken responsibility for the proper development of their message.

Commercial weight loss ads put up a unified front – they appeal to people who are sick of the pain of being overweight. Commercial food and restaurant advertisements also put up a well-funded message – they put a big "eat me" sign on every edible formation out there.

But socially motivated advertisements are few and far between. It’s rare to find someone taking responsibility for motivating social change – the returns aren’t monetary and the measures of effectiveness can take years to adequately estimate. However, their potential for success is impressive.

Consider, for example, the advertisements that big tobacco companies were ordered to publish as anti-smoking campaigns. In just a few short decades the social climate has gone from one where nearly everyone had a cigarette in their hand to one where smoking is
outlawed in all of some cities' public places. I believe that this type of social cause advertising, with a correctly positioned message, has the potential to be extremely effective.

**Risk Behavior Application**

This framework is not only applicable to inactivity and the obesity problem – other risk behaviors can be approached as well. Binge drinking and reckless/aggressive driving are two of the most prevalent.

The horror stories are out there. The statistics are out there. But we're not listening. Advertising has the potential to make the pleasure of behavior change comparable to the pleasure of the current risk behavior.

**THE OBESITY PROBLEM**

As the ball dropped on the December 31, 1989 New Year's Celebration, the decade of the eighties came to a close. Nintendo released the Game Boy. Hip Hop first hit mainstream music success. Pete Rose was banned from baseball. “The Simpsons” television show premiered on FOX. Widespread Internet availability was in the works. (Wikipedia 2004) Less than 56% of Americans were overweight. Obese people made up 23% of the population. (U.S. FDA 2004)

In 2004, fifteen years later, most of 1989’s new technology is obsolete, the popularity of “The Simpsons” and Hip Hop continue to wax and wane, and the Internet has
changed the way the world operates. In addition, over 64% of Americans are overweight and 30% are obese (U.S. FDA 2004). America’s collective girth is growing.

Even more alarming than the simple increase in the percentage of overweight and obese people are the relative growth rates of these two categories. While the rate of change in the overweight population was a quick 14%, the obese population grew at a rate of 30% - more than twice as fast.

It’s obvious, then, why the national epidemic has been termed “the obesity problem,” and not “the overweight problem.” The population, as a whole, is not only getting bigger, they’re getting MUCH bigger.

According to the North American Association for the Study of Obesity, the condition is defined by a Body Mass Index (BMI) greater than 30 (NAASO 2004). Body Mass Index is a measure of body weight relative to height. It is calculated by dividing weight (in kilograms) by height (in meters) squared (Robbins 377).

**Impact**

Those with BMI levels at or above 30 are at much greater risk for many serious health problems. Type 2 Diabetes, cancer, sleep apnea disorder, musculo-skeletal disorders, coronary heart disease, and many gastrointestinal disorders, such as fatty liver disease, gastroesophageal reflux disease, gallbladder disease, and severe pancreatitis are just some of the potentially chronic health problems that are closely associated with obesity. (Haran 2004, Getting 2002).

In addition to obesity’s related physical ailments, low self-esteem and other emotional ailments cause immeasurable suffering. Critics of the media blame movies,
television and fashion for promoting an unreasonable image of attractiveness. Even historical beauty Marilyn Monroe isn’t immune to taunts about her weight. English actress Elizabeth Hurley (of *Bedazzled* and *Austin Powers* fame) was quoted in Allure magazine as stating “I’d kill myself if I was as fat as Marilyn Monroe.” (ThinkExist 2004)

The stigma against being overweight and/or obese is growing, almost as fast as the measurements of the population. This creates an ever widening chasm between the ideal and existing states.

The emotional and physical ailments associated with obesity cannot be left untreated. Nor will they – they represent a growing market for those in the medical profession.

Obesity-attributable medical expenditures cost the U.S. $75 billion last year (Media Relations 2004). Add lost wages and other compensatory costs to that figure and estimates jump as high as $300 billion. The National Business Group on Health estimates that U.S. companies spend around $12.7 billion on obesity-related costs annually. “Health costs go up within each BMI category,” says researcher Dee Edington, director of the Health Management Research Center at the University of Michigan. “Even a one BMI unit increase translates into dollars.” The article in HR Magazine goes on to site the center’s study of 18,534 GM employees, which shows drastic growth of medical and drug costs as BMI categories increase. The 11.7% of GM employees in the “BMI greater than 34.9” category make up 33% of company’s medical costs. (Grossman 2004)

Obvious costs of obesity in the workplace include medical insurance and related diagnostic and treatment care. Some other monetary costs that are often overlooked
include disability and life insurance rate hikes. Costs that are more difficult to measure include decreased productivity and increased absenteeism. According to Grossman’s HR Magazine report, “Obese employees are twice as likely to be absent 14 or more times per year.” (2004)

In today’s society it’s rare to find someone who doesn’t recognize the significance of an increasingly obese population. However, discussion of the topic often meets with disapproving glances. Related food disorders anorexia and bulimia have created an environment where people are afraid to approach the subject of obesity in order to find viable solutions.

Gary Crister, in an editorial for Forbes magazine, poses the question, “When did it become immoral to tell people they’re eating too much?” (2003) Likewise, it’s always been rude to tell someone they should exercise more. Finally, it’s just ridiculous to mention that someone should choose a breeding partner with ‘non-fat’ genes, so that children have a hope of avoiding obesity. Society and humanity make it difficult to talk to people about the three main causes of obesity. Without talking about the problem, how can we ever reach solutions?

Causes

According to dietician Sandra Hassink, MD, many factors go into creating the obesity problem. The three broadest concepts are the family contribution, eating habits, and inactivity. Several underlying issues, such as living environment, psychological state, illnesses and drug use can also contribute to these main factors. (2003)
None of these factors seems to prevail as the most common cause of obesity. However, the family can be instrumental in the development of a child's relationship with food. Seventy percent of children with obese parents are also obese. When only one parent is obese, forty percent of children are obese. When neither parent is obese, ten percent of children are obese. (ECureMe 2003) While it's not a certain determinant of obese offspring, there is certainly a high possibility that obese parents produce obese offspring. This correlation exists because "the lowest body fat percentage is genetically set." (ECureMe 2003) However, experts know that it's hard to say how much influence the actual genes have on obesity.

The confusion exists because families share such similar habits and attitudes toward food. Sandra Hassink states that "some of your genes tell your body how to metabolize food and how to use extra calories or store fat," but those extra calories and fat may be getting there because of the approach to eating that is passed down through your family. (2003)

Whether those eating habits come from the values passed down by parents or from lifestyle choices, they are also a big contributor to the obesity problem. Americans eat much more now than ever before. According to Anorexia Nervosa and Related Eating Disorders, Inc., "in the late 1990s Americans ate about 340 more calories per day than they did in the mid-1980s, and about 500 more calories per day than in the 1950s." (ANRED 2004) At 1500 calories per pound, three days of extra consumption can cause one pound of weight gain.
These extra calories come from a variety of sources. Most prevalently, portion sizes are to blame. Since the 1950s, the average size of a hamburger has grown more than five-fold, from 1.5 ounces to a whopping 8 ounces today. (Hassink 2003) Coca Cola was bottled in tiny 6.5 ounce bottles. (Columbia 2002). Even with recent trends to make smaller cans have created a market for 8 ounce cans. Six and a half is one gulp to Coke drinkers today.

In addition to larger portions, the number of meals eaten away from home has increased in the past decades. Though home-cooked meals aren’t always the lowest in fat- and calorie- content, they do tend to be lower in empty calories (sugars and fats) and offer a more balanced offering than meals eaten out. (Dairy 2003) Last year’s data actually did see a slight decline in the number of meals eaten out, probably because of the slumping economy. (Seattle 2003)

Now that half of the money spent on food is used to eat out, and four out of five meals eaten out are ordered while sitting in a car, it’s clear how those extra calories got tacked on to each day. (Seattle 2003) Considering recent popular attempts by many to diets that extra 500 additional calories a day is even more astounding. For those who are sick of the dieting crazes, that average means that there could be even more people gorging themselves than there are people dieting.

Eating habits certainly have changed. But weight gain and the obesity problem aren’t just contingent on consuming more and worse calories. The weight gain equation is simple, “calories in” > “calories out” = “calories added.” Not expending enough calories is just as much to blame for obesity as eating too many calories. (Largeman 2004)
Today’s society is focused on convenience – drive-up windows, internet shopping and food delivery are just some of the conveniences that have reduced expended calories and activity levels. Entertainment also contributes to the couch potato culture. Video games, television, and movies all play much larger roles in the lifestyles of today than they have in the past. In addition, schools have placed decreasing emphasis on physical and fitness education since the early nineties. (Buchanan 1991)

Our convenient society gives us all kinds of excuses to avoid real physical activity. Electric handicapped doors, escalators, power windows, power steering, remote controls, riding in the car for even a short trip to the store, and using elevators instead of stairs or ramps all contribute to our inactivity. The growing impact of these ‘conveniences’ can best be seen by comparing them with life before – or without – their use.

A number of studies of Old Order Amish populations, who use no electricity and still do all of their food and clothing production by hand, have shown that the Amish are able to keep closer to ideal body weights through increased activity. This is particularly significant in pointing out the contribution that inactivity makes to obesity, since the eating habits among the Amish aren’t considered healthy, by any means. They consume homemade foods high in fat, calories, and sugars. Despite this diet, only nine percent of Amish women and none of the Amish men are obese, compared to an obese 31 percent of Americans. These studies liken Amish life to mainstream life 150 years ago – around the 1860s. Some would say we’ve made a lot of progress since then. We’ve taken away the need for hard, physical labor as a part of daily life and we’ve made it so we never have to
walk more than ten steps to get to our destination. And look how fat we’ve become. (Wart 2004)

Another difference the Amish have on mainstream culture is their lack of dependence on television and video games for entertainment. Despite taking time away from physical activity, these hobbies are actually reported to cause increases in food consumption as well. This is especially caused by commercial television, with its junk food ads, its constantly eating, perpetually skinny sit-com characters, and even its entire network dedicated to the worship of food. (Buchanan 1991)

But the factor that affects inactivity even more than all of the advertising and other food-related messages on television is the LACK of opposite messages in schools. Even back in the early nineties, Buchanan cited a General Mills study that the most frequent source of nutrition information, besides doctors, was television. Only four states require physical education throughout all grades and only one state require it every day. Even in states that do offer and/or require physical education, it is of the wrong variety. The focus of these classes has always been on sports and activities, and not the background information for WHY sports and activity are so important to being healthy. (Buchanan 1991) Decreased funding in school districts around the country has made physical education, along with many other programs, a low priority.

Solutions

Fortunately, governments around the world have begun to understand that if the obesity problem is kept as a low priority, obesity-related problems are going to slowly eat
away at the social systems in place for health care, retirement funding, and poverty assistance. Many studies have been done about the American epidemic and hundreds of different opinions exist as to how to tackle it. In an attempt to simplify the often contradictory views it's easiest to look at the big picture. Since family, food, and failure to be active are the three main causes of obesity, they provide the best view of the big picture, as far as solutions are concerned.

Genetics are one area that humans have yet to fully control. Obviously, since their influence on obesity isn’t completely known, we are unable to harness the possibilities of genetic alteration in order to prevent it. The North American Association for the Study of Obesity, however, does list doubling funding of research on obesity as one of their top recommendations for tackling the problem. Thomas A. Wadden, Ph.D., vice president of NAASO, in a report before the United States House of Representatives Committee on Government Reform (subcommittee on Human Rights and Wellness), stressed the importance that research into the obesity problem has on the future of American health care. In addition, he reported that reducing the development of obesity in young children, through preventative education and vigorous positive example-setting in the home, is one of the main ways we can gain headway in reducing the occurrence of this deadly disease. (Wadden 2004)

The United States Food and Drug Administration have also published guidelines for reducing the obesity problem. Their ‘Obesity Working Group’ began in August of 2003 and has since come up with several sets of recommendations for both reducing individual
weight and changing the societal climate to better support those with weight loss plans. They stand behind the idea that there is “no single cause” for obesity, just as there is “no single solution.” Also focusing on the “calories in = calories out” mentality, they urge Americans to consume less empty calories (fats and sugars) and to become more active in their daily lives. (United States Food and Drug Administration 2004)

The third big picture of obesity, failure to stay active, was also discussed during the NAASO’s presentation to congress. Wadden announced that a seven percent reduction in weight and just 150 minutes of physical activity a week (that’s 22 minutes a day or just half an hour five days a week) is enough to reduce the risk of obesity-related health problems by greater than 50%. (2004) At only 30 minutes a day, he’s talking about parking at the far end of the parking lot, taking the stairs instead of the elevator, and walking to the store instead of driving that five blocks to pick up milk.

Wadden suggested that the solution is an individual one. Each person eating less and being more active are enough to solve the obesity problem. (2004) However, this individual change must be widespread if the country is to see a significant turn around. Individual change and teaching our children correct eating and exercise habits can have an effect, but the social environment makes it more difficult than Wadden makes it seem.

Society

One of the NAASO’s biggest recommendations to the U.S. government is that there be a better support and treatment system for obesity in this country. A 2002 study that helped support some of Wadden’s recommendations found that frequent counseling was
actually one of the main factors in the success of patients attempting to reduce the risks of obesity-related health problems. In all cases, this counseling was NOT covered by the participants' insurance plans. In general, Wadden claims, insurance companies pay to treat the complications of obesity but do not pay for its prevention or the obesity itself. (2004) They will cover the insulin to treat diabetes and the open-heart surgeries to counter heart disease, but if even a morbidly obese person (BMI of 35 or above) needs clinical or counseling help to lose weight, they must pay out of pocket.

Finally, a social stigma has been attached to discussing people's weight. For this reason, even many doctors fear mentioning to patients that they could benefit from weight loss. (Vinson 2002) Fear of being rude merely makes doctors enablers, rather than the leaders we need during this epidemic. People need to be better educated in order to help society become more comfortable with discussions about weight loss. They need to know what causes obesity, what we can do to stop obesity, and why all of this is important. Mass communication can effectively convey this message, if those with monetary resources are willing to help get it in front of the people who are most affected – the general public. Public service advertising initiatives need to be supported from all levels of government and the private business sector.

CURRENT INITIATIVES

This idea is not new. In the past two years, awareness of the obesity problem has motivated many influential groups to begin advertising initiatives focused on reducing its
effects. Both the Centers for Disease Control and Prevention and the Ad Council have developed campaigns to battle obesity.

The first, a campaign focusing on the ‘tween’ age group (9 to 13 years old) is the CDC’s weapon against the childhood obesity problem. The growth of television, video and computer games, and telephone availability have affected this age range even more significantly than adults, since they participate more frequently in leisure time activities. (CDC 2004)

The campaign, titled VERB, encourages tweens to choose a verb and do the action every day. Offered with a multicultural overtone, the campaign is presented in both English and Spanish. The slogan “VERB: It’s What You Do!” communicates the importance of remaining active, rather than falling into a sedentary after-school routine. The campaign also offers many support services for parents and educational facilitators interested in developing the message further with their own children. (CDC 2004)

This campaign is a first for the U.S. Government in that it is voluntarily sponsored by corporate entities, as well as public funds. Companies that have successfully marketed to this age group have cooperated to provide media slots, endorsements, and other exposure for the campaign. Involved companies include DC Comics, AOL Time Warner, Disney, Primedia and Viacom. (Hispanic Health 2002) This is called the “CDC’s biggest public awareness effort in 20 years.” (Study 2004)

However, VERB’s effectiveness is a question up for debate. One year in, “about 74 percent of American ‘tweens’ are aware of the campaign.” (Study 2004) This fact is much publicized by the CDC, who had expected a lower recognition rate. Despite this
recognition rate, have obesity rates among the ‘tweens’ actually seen a change? It’s too early to tell, but the fall of 2004 has seen another influx in news reports concerned with childhood obesity. One year certainly isn’t enough to turn 31.5% of the nation’s children (No Decline 2004) around – only time will tell if the VERB campaign will successfully trim that number down.

Another U.S. government agency, the Ad Council, has taken responsibility for the development of another campaign aimed at reducing the occurrence of obesity. The “Small Step” campaign is focused on families and encourages them to make small dietary and physical activity changes in their every day routines. There is a list of 118 ‘Small Steps’ that everyone can take to live a healthier lifestyle. The steps include tips like “58. Walk briskly in the mall,” “89. Try your burger with just lettuce, tomato and onion,” and “108. Every time you eat a meal, sit down, chew slowly, and pay attention to flavors and textures.” (US Health & Human Services 2004)

Though these small tips are the basis for the “Small Steps” campaign title, they’re not the entire substance of it. There is a four step process that goes along with including these small lifestyle changes.

First, get the facts. “We are bombarded every day with conflicting information about our health. Is it better to eat a low-carb diet or a balanced diet? Should we be physically active three times a week or five times a week? And how can we be expected to follow any of these recommendations when we’re always so busy?” queries the Small Step website. (US Health & Human Services 2004) The answer to these questions, it goes on to say, is to control portion sizes and eat a balanced diet, increase activity, and abstain from
use of tobacco and illegal drugs. The key to the Small Steps plan is recognition that though these solutions may sound easy, they're not – but small steps toward accomplishing them can be extremely effective. The other steps in the process include (2) eat better, (3) get active, and (4) learn more.

The promotion of this process and the Small Steps incorporates humor through print, television and radio ads that portray people finding lone body parts in odd locations. For instance, some kids playing in on the beach find a rotund belly popping up out of the sand. “Probably lost it walking on the beach,” one comments. “Small step #92,” scrolls across the screen, “Walk instead of sitting around. Take a small step to get healthy.” People in the ads are unsurprised to see body parts lying around town and automatically attribute it to choices the parts’ previous owners made in living healthier lives. (Ad Council 2003)

The campaign was launched in March of 2004, and research on the campaign’s effectiveness has yet to be widely published. However, due to the funny, light mood of the advertisements, exposure on prime-television shows have led to exposure of the message. During pre-run test marketing, the campaign’s average “likeability rating” was unusually high for nonprofit advertising – around 89%, compared to the normal 77%. The 89% rating is even greater than most for-profit advertisements, which usually score around the 87% mark. Focus groups indicate that the reason for such affect among consumer groups stem from the campaign’s idea that weight loss and healthy living come from small, manageable activities. (Kersten 2004)

However, the campaign has come under some criticism. Representatives from the American Obesity Association consider the portrayal of those small, manageable activities
as trivializing weight loss. The advertisements are “misguided and an insult to obese people,” Judith Stern (co-founder and vice president of the AOA) commented. “The campaign ‘tells obese people all they have to do is walk a little bit and they won't have a belly, and they won't have love handles and they won't have a double chin - and it’s not so,’ she says.” (Kersten 2004)

Though the message of the campaign is under debate, it's clear that the Ad Council and the Department of Health and Human Services are serious about contributing to a reduction in obesity rates. These American institutions have foreign counterparts in the war on obesity.

The British government has also begun a series of ads focused on their obesity problem. Sport England, the organization overseeing the promotion of sport in the country, has developed a campaign based around the “Champion Family,” which is to represent activity and healthiness throughout the nation. The idea, Sport England’s website explains, is to provide an everyday family that believes in the importance of health and activity and works it into their daily lives, as an example for other families to emulate. (Sport England 2004)

The Champion Family represents one aspect of Sport England’s battle against growing obesity rates. The Game Plan, released in 2002, outlined an ambitious set of goals set forth by the organization. One objective is to convince 70% of the population to engage in regular activity – meaning at least 30 minutes of vigorous activity at least five times a week – by 2020. (Department for Culture, Media and Sport 2004)
Other initiatives in Sport England’s campaign include building new sport facilities, such as skate parks, tennis and netball courts. In addition, initiatives, such as a dedicated sport development worker at some facilities, to encourage use of existing facilities are being investigated. (BBC 2004)

Advertising for the campaign seeks to increase awareness of the various initiatives, while promoting sports and physical activity. The goal is to “create a public health campaign similar to the drink-driving ads. We want to change peoples’ attitudes and behavior, but there needs to be a sustainable effect to meet longer term government targets,” said Nick Wake, head of Marketing for Sport England. (Thomas 2003) The campaign, “Britain on the Move,” was launched in April of 2004 and its sponsoring media, ITV has since recorded “over 150,000 calls with 90,000 requests for the free information packs and 520,000 hits on the specially built website.” (Eustace 2004)

Campaigns that affect awareness of the obesity problem are not always directly focused on it. The American Heart Association’s Cholesterol Low-Down campaign teaches families what they can do to prevent heart disease. Using various spokespeople, such as Regis Philbin, Debbie Allen, Dick Clark, Mary Wilson, Vicki Lawrence, Valerie Harper and Henry Winkler (a.k.a. the Fonz) the public relations campaign pushes the message that high blood pressure, obesity, smoking, high cholesterol, and lack of physical activity are the preventable contributors to Heart Disease, the number one cause of death among American men and women. The program is sponsored by Pfizer Inc., the pharmaceutical research company that created Lipitor, one of the leading cholesterol
control medications. It was launched in 1998 and the number of enrolled members has reached 140,000. (Campaign 2002, American Heart Association 2004)

In addition, a number of other initiatives have focused on tactics other than advertising. For example, the Center for Disease Control has developed a financial plan to provide resources to schools for better education and Arkansas is using legislative avenues to support the development of an insurance plan that will encourage healthy behaviors.

The CDC’s Healthy Youth program provides money to schools to educate about reducing all risk behaviors, not just inactivity and over-eating. The founding principle behind the initiative is summed up by a quote from the Carnegie Council on Adolescent Development. “Schools could do more than perhaps any other single institution in society to help young people, and the adults they will become, to live healthier, longer, more satisfying, and more productive lives.” (Center for Disease Control and Prevention 2004)

The main risky behaviors focused on in this program include the following: tobacco use, unhealthy dietary behaviors, inadequate physical activity, alcohol and other drug use, sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases, including HIV infection, and behaviors that contribute to unintentional injuries and violence. CDC’s efforts for the reduction of these risk behaviors focus on identifying and monitoring them, analyzing them and educating schools on how to implement reduction programs, providing financial support to allow states to implement their own programs and to support the CDC’s VERB campaign for more active youth (see above). (Center for Disease Control and Prevention 2004)
Clearly, reaching youth and educating them about the risks of unhealthy behavior is a way to develop future adults who are conscious of their own health. However, as Secretary of the Department of Health and Human Services Tommy Thompson has pointed out, the costs of living a healthy life can, for some people, outweigh the benefits. Specifically, preventative health care costs prohibit many of those who are at-risk for obesity from seeking help. (Thompson 2004) Thompson has indicated that he’d like to see health insurance incentive programs for healthy lifestyles, much like the safe driver and good student incentives given on automobile insurance premiums. (Senay 2003)

One such program is already in the works. Arkansas, concerned with its status as one of the fattest states in the country, has been hard at work to develop insurance credits for state employees that are based on steps toward more healthy living. Fay Boozman, director of the Arkansas Department of Health, points out that “You can’t confuse medical care with health. America is the place to have a heart attack, not prevent it.” The state’s new program aims to change that, and to make their focus on prevention, rather than treatment. (Arkansas 2004)

The focus of the program will be incentives for healthy behaviors, rather than punishments for unhealthy ones because of the recognized difficulty in changing lifestyles. Some indicators are hereditary and others are habit forming. Punishing these behaviors could lead to claims of discrimination and prejudice. So the new incentives will reward measurable improvements in factors that are widely accepted as risk factors for obesity and/or other preventable health problems. Blood pressure, cholesterol, blood sugar, weight loss and quitting smoking are all being proposed as factors in the reduction of insurance
premiums. Maybe introducing cost and economics into the picture will make people wake up and see the problem, theorizes Arkansas governor Mike Huckabee. (Arkansas 2004)

All of these strategies (advertising, education funding, and insurance reform) seek to accomplish one goal — to change the social climate of the problem. Advertising reaches out to the public in an attempt to change perceptions, while education and insurance reach deeper into the problem in an attempt to change its tangible assets. While all three of these directions represent important paths toward a smaller America, one has the ability to influence the acceptance of the rest.

In the current climate, adequate support for nation-wide insurance reform and educational funding increases is hard to rally. These decisions and changes require lawmakers and lobbyists at all levels to come to some consensus about the ideal levels of regulation and funding. However, advertising is a much more privately-influenced issue. Anyone with enough resources can begin to change the public attitude through advertising. With increased advertising initiatives to impress the importance of the problem and to urge individual action, the future climate may be more receptive to the broad changes it will take to become a truly healthy nation.

CHANGING BEHAVIORS

Advertising can greatly influence the opinion of the general public, but, as noted, obesity is a highly personalized disorder, and individual changes must be approached with individual consideration. For this reason, obesity is faced with the same problems that
many other health issues face. Reaching the public with effective behavior change messages is difficult. The concept of social marketing deals with this and many other challenges.

It can be said that the goal of marketing, in general, is to influence behavior. Where traditional marketing practices focus on persuading a consumer to purchase a product, social marketing uses the same tools to motivate and influence change. Behavior change can be seen as a product/service that the marketer must sell to the consumer.

However, selling a behavior change, while comparable to selling a product or service, can be much more difficult. Products and services are based around benefits to the customer and, in many cases their only cost is monetary. Behavior change deals with much greater psychological issues. Often pain and cravings must be endured and pleasure and enjoyment foregone, in addition to monetary costs for treatment. The act of purchasing and the act of changing are closely related, but if they are viewed as one and the same, several important decision factors are wrongly viewed as insignificant. Creating a message and plan for change that properly utilizes these decision factors constitutes social marketing.

Succinctly, the “bottom line (of social marketing) is influencing behavior” (Goldberg, et al 1997) Alan Andreasen, in his article Challenges for Social Marketing, is careful to differentiate between this purpose and some others, with which social marketing is easily confused. “Social marketing is about behavior change. It is not about education and propaganda, and individuals should not imagine they are doing social marketing if their primary goal is informing the public or trying to change some basic values.” Indirectly,
Andreasen is noting that behavior change does not come about through simple informational appeals.

One common method of approaching the psychology behind general marketing is to look at behavior as response to a stimulus. Traditional psychological theories based on this "black box" concept ignore the processes of the mind and focus on the external factors involved in behavior. In goes the stimulus (information from a commercial or package) and out comes the behavior (purchase or patronage). These theories, developed in the early 20th century, can be applied to low-involvement decisions, such as toothbrush and laundry soap purchases, but high-involvement purchases and behavior change are highly cognitive processes where conditioning is ineffective. In order to influence significant behavior, the "black box" must become transparent and the processes of decision-making and behavior change examined.

THEORIES OF BEHAVIOR CHANGE

Traditional Theories

Several theories about these processes exist and can be grouped under two main philosophies. First, social-based theories of behavior change are exhibited by the Social Cognitive Theory, which teaches that modeling of desired behaviors induce change by making the task seem accomplishable. Second, individual-based theories, such as the Theory of Reasoned Action, trust that the human mind is inherently rational and will modify behavior to fit that which it believes, through analysis of their surroundings and their own intentions, to be most beneficial. (Slater 2000) Neither of these classes of
theories properly takes into account the effects of the other. Both environmental and personal factors play large roles in influencing behavior change.

For this reason, a third group of behavior change models has emerged. This group combines other theories for a comprehensive look at what actually influences behaviors. The Transtheoretical Model, also known as the Stages-of-Change Model, outlines the cognitive states through which people travel when undergoing a major decision or process of change. (Robbins, et al. 2002)

**Transtheoretical Model**

The Transtheoretical Model is based on five stages — Pre-contemplation, Contemplation, Preparation, Action, and Maintenance. These stages can be viewed as the ignored process that is carried out inside the “black box” of the conditioning theories. The focus is on the “progression through five stages,” not “viewing behavior change as a single event” (Robbins, et al. 2002).

Pre-contemplation is the stage of this process when people do not realize or admit that there is a problem. They are either unaware or improperly informed about the issue. In some cases, they have not yet realized that their behavior is one of the ones they’ve been hearing about. “Pre-contemplators are often viewed as unmotivated, uncooperative, and defensive” (Robbins, et al. 2002), primarily because they have not yet admitted, even to themselves, that they need to change their behavior.

The second stage, contemplation, signals awareness of a problem, but uncertainty about change. Contemplators may have decided that they’d like to change, but don’t know how to go about it, or they may not know if they want to change. People can stay stuck in
this stage for long periods of time, as they are looking for the benefit that will make the change worthwhile. (Robbins, et al. 2002)

Once the contemplator values the benefit of changing more than the pleasure of the behavior, they become committed to action. These people are seeking information about how to best maneuver the change and to adjust to the new lifestyle. Their concerns are based on how to accomplish their goals and be successful. (Robbins et al 2002) This constitutes the preparation stage which is necessary before proceeding on to action.

The fourth stage, action, is the most time consuming and physical of all the stages. It is also the most visible. Confidence and self-efficacy (belief in one’s ability to accomplish the goal) are important, so “working toward small, attainable goals is important” (Robbins et al. 2002). The action stage lasts for at least six months before people move into stage five – maintenance.

Maintenance is characterized by the constant sustenance of the new behavior. It can be difficult, but as time goes on the person becomes comfortable in the new routine. In addition, their confidence grows as they realize that they have been successful. The most important part of this phase is relapse prevention. Keeping the undesired behavior at bay can take effort and time, but can be drastically influenced by surroundings. Part of developing a new behavior is developing a supportive environment. (Robbins et al. 2002)

The Transtheoretical model does not always have a linear flow. Often, people cycle through these stages in periods of relapse as they lose and rediscover their motivation. (Robbins et al. 2002)
The time it takes to move through these stages is based on each individual’s readiness to change, resources needed to change (often time or money), self-efficacy (belief that they can change), environment, and any number of other, personal factors. These factors represent numerous opportunities for outside influence to either speed or slow the process.

**Transtheoretical Model of Behavior and Advertising**

One recent criticism of the advertising industry is that the marketing of fast food restaurants and junk food are irresponsibly hindering society’s change process. Potato chip and soda companies have come under fire for promoting their products in schools, through advertising and sponsorships. Schools receive monetary and audio/visual equipment donations from corporations for broadcasting Channel One, an educational television station, in the hallways and cafeterias. (Getting 2002)

But Channel One is a very small part of the problem. School children aren’t the only ones susceptible to the cunning of marketers. And Pepsi and Frito Lay aren’t the only companies that advertise unhealthy foods. In the United States alone, “more than $33 billion per year is spent on advertising sugary soft drinks, candy, and fatty snacks” (Robbins et al 2002) to all age groups, races, and geographic areas. This incredible figure makes it difficult for the government and non-profit organizations to keep up with counter-advertising and other social messages teaching healthy assortments and physical activity.

Certainly the diet products industry contributes to awareness of the weight issue and works to counter this junk food advertising, but it does so by providing mixed, and often unhealthy messages. The unscrupulous reputations of these products and the unbelievable
claims they make can sometimes work to detract from individual efforts to lose weight and improve lifestyle by reinforcing negative beliefs about one's ability to make such a great change. When even the self-proclaimed "miracle drug" can't help, self-efficacy becomes vulnerable.

Clearly, diet drug advertisements are not the best way to guide individuals through the process of behavior change, but marketing has many aspects and non-commercial advertising holds much promise in the attempt to change unhealthy behavior. Specifically, the Transtheoretical model of behavior change can act as the driving theory behind social marketing campaigns.

Rosemary Thackeray and Brad L. Neiger, in an article for the *Journal of Health Education*, discuss the complementary aspects of behavior change models and social marketing and urge professionals in both fields to cooperate in further researching possible applications of the conjoined theory. Behavior change theory, and more specifically the Transtheoretical model, can be logically used in a marketing context because each of its stages can be directly linked to the traditional objectives of marketing campaigns.

Primarily, the model itself is synonymous with the main goal of all marketing – to influence behavior. (Goldberg et al 1997) The model aids understanding of the personal factors involved in the process of change and can therefore help marketers understand what makes their markets' minds work – whether they are attempting to get their audience to change brands of laundry detergent or change to a more healthy lifestyle.

At any given moment, concerning any given subject, each human being on the planet falls into one of the five stages of behavior change. Broken down, the first stage in
the Transtheoretical model (pre-contemplation) represents a range of attitudes and awareness levels. It begins at the end of the spectrum where people are completely unaware or uneducated about the issue and ends with those people who are aware that the problem exists but are not aware of their role in the problem or the influence the problem has on them. Much like consumers who are unaware of a new product launch or unaware of a particular functional need they may have, in order for pre-contemplators to move to the contemplation stage they must become aware of the issue (product) and recognize how it applies to their life (their functional need).

Raising awareness of an issue (much like raising awareness of a product) often involves promotional campaigns that seek to inform the public about a particular problem or cause. Motivating movement from the first stage involves informational appeals that touch on both the important facts and the pressure points of the issue—the points that can make a person realize that the issue applies to their life. Michael Slater, in an article about communication and behavior change theories, stresses that simple messages from credible sources are the best way to get attention and raise awareness. (2000)

If people first become aware of an issue (the first part of stage one) their belief that they are unaffected by the issue will likely remain solid until one of the pressure points has been activated. Often, awareness can be raised while pressure points are described, and both conditions for movement from the pre-contemplation stage will have been met.

At this point, a person moves into the contemplation stage of the Transtheoretical model. Contemplation is characterized by the understanding of one’s relationship with a particular issue. Contemplators’ attitudes may vary—resentful feelings toward themselves
or the issue can be harbored, relief may be felt from the pinpointing of a nagging feeling, or excitement may grow at the anticipation of making a change. No matter what the emotion involved, contemplators all share one thing — there is some hurdle keeping them from committing to a plan for change.

In many cases, this hurdle comes in the form of negative beliefs and/or expectations about the change. (Slater 2000) Maybe a contemplator fears that they will miss the buttery taste of their favorite food and the extra half hour of sleep they will lose if they begin a diet and exercise plan. Maybe the threat of physical symptoms of withdrawal keeps them from making a change. Or maybe they just don’t believe they will be successful. No matter what the hurdle, marketing can help people realize, identify, and overcome it.

Traditional marketing objectives linked to the transition between the contemplation and preparation stages of the Transtheoretical model aren’t as obvious as in other transitions. It’s not as simple as getting people to realize a problem or to stay on track — it’s more about building commitment. It can be likened to brand loyalty issues in traditional commercial marketing. A customer is aware of a particular brand, but it takes product trial and constant reminder of product benefits and a trust of the company to build loyalty to that brand.

In social marketing applications, it involves getting contemplators involved in the decision, making it personal, and attacking the hurdles keeping them from preparation. Slater remarks that persuasive narratives are more effective, in this stage, than facts, because people are already educated about the subject and are working to build connections
The goal of marketing to people in this stage is to overcome or counter negative beliefs and expectations about the change.

If these hurdles are overcome, a person will move into the preparation stage. Here they are making plans for the adoption of their new behavior and are gathering information that will help them to be successful. At this stage they need reinforcement that they’ve made the right decision and easy answers to technical questions. Hurdles to their acquisition of knowledge can put them on a cyclical path back into contemplation or, even worse, extreme frustration could send them back to pre-contemplation.

Slater suggests that marketers again revert to an informational standpoint and provide information about the change. In addition, the information’s availability should be promoted so that people know and feel that there are resources out there to help them. The last feeling they should have is that they must re-invent the wheel. (2000)

Slater cites the Social Cognitive Theory as the basis for his recommendations on campaigns dealing with this stage of change. The combination of the environment and the person’s attitude about the environment are important to make them believe that they can accomplish the goal of changing their lifestyle. Specifically, he cites modeling as a successful technique for boosting self-efficacy and displaying proper methods and techniques. (2000)

For example, Subway’s Jared campaign uses Jared as a model for the way they’d like other customers to behave – they’d like them to walk to Subway, eat healthy, and walk back. Jared is not only a spokesperson, he is the model of a weight loss success story, and can help people plan their own routes to success.
Marketing at this stage is much like retail marketing in the commercial arena. Customers have decided to buy the product, but are now responsible for the logistics of the decision – where to purchase it, how to pay for it, and the terms of the sale must all be negotiated within their own minds – how will they bring about the change in their own lifestyle?

Successful planning stages are relatively short. Once people become truly committed to changing themselves, they are usually anxious to get to work. (Robbins et al 2002) Action is a stage primarily based in reinforcement. To follow the commercial marketing analogy, the customer has made their purchase and the focus of marketing is now to reduce the post-purchase dissonance felt as the product is consumed. As people begin to follow the action plan they have set out for themselves, they must be reassured that they are on the right track, that the change is really the best for them, and that they really have left those hurdles behind.

Slater’s comments on the fourth and fifth stages of change (action and maintenance) are similar – he suggests reinforcement in volume. (2000) Like raising awareness to move from pre-contemplation into the contemplation stage, action and maintenance are focused on keeping awareness and the motivation to continue.

And the old saying about customer service applies as well...each unsatisfied customer tells six other people about their experience. Often, behavior change takes such effort that it becomes a noticeable part of a person’s life. If they feel confident in their abilities and experience, they will likely inspire change in others. If they are let down and unconvinced of the merits of change, they are likely to discourage others.
A sweeping change in society may not be an easy task, but it can begin with individuals and their experiences. Behavior change theory gives social scientists a unique understanding of the processes of change within the human realm; it’s up to marketers to learn from those processes, as well, to develop campaigns that aid society in a collective overhaul of unhealthy behavior.

DEVELOPING MESSAGES FOR CHANGE

The central aspect of campaigns that will aid society in this venture is an applicable message. As the Executive Director of the American Public Health Association once noted, “the reason for unhealthy behaviors is not that the public does not fully understand the healthy ones.” (Benjamin 2003) Instead, he explains, people hear the messages and process the information, but in the end, the messages being broadcast are “tough to reconcile with reality.” This lack of focus on the issues most important to peoples’ decision making and behavior change attitude processes renders messages irrelevant. Though broad messages may reach more people, objectives like encouraging behavior change and reducing risky behavior are better served by powerful messages aimed at particular targets.

Recognition of this concept is what has driven the Center for Disease Control to target tweens with its VERB campaign and older adults through the American Heart Association’s messages. Whether these campaigns have been approached with relevant messages is beyond the scope of the current topic, but their existence indicates recognition
of this need for individualized messages. But there is one group that has not been the focus of any significant social campaigns—the young adult (18-24) market.

Widely recognized as the prime consumer market, the 18-24 group is known for its ability to set trends. In addition, one of the main attractions of this market is its tendency to grow into positions of even more power, as they soon become household decision makers and even holders of influential positions in society. Beyond their future potential, young adults also are in a stage where their future behavior is greatly molded. In many cases, people in this age range are experiencing the ability to make decisions, such as grocery purchases and leisure activities, on their own for the first time.

All of these factors represent an excellent opportunity for marketers to influence the collective attitudes of a society in the years to come. On a smaller scale, this influential time in life represents an opportunity to reach a market that is beginning to develop their personal independence and lifestyles.

However, this market’s potential for success, while providing opportunity also provides great challenges to social marketers. First, a market purely identified by a range of ages will undoubtedly have a wide variety of individual personalities and demographic groupings. Clearly one message cannot hope to be relevant to all members of the age group, especially in this particularly formative stage of human growth. The difference between 18 and 24 may only be six years, but often mean the difference between high school and professional employment.

Undeniably, these transitions are formative to the personality and lifestyles of a person, and it is this development that makes the market attractive to social marketers. At
the same time, different stages of development are difficult to gauge, thus making specific message and target audience decisions more complicated. The old phrase “no pain, no gain” comes into play, as advertising to this group is made more difficult by the very opportunities it provides.

With such a vast array of people within this market, it’s obvious that the market will have to be further segmented to develop messages most relevant to its members. Out of pure convenience, this discussion will focus on college students. More specifically, the informal study to follow narrows focus to students enrolled in Marketing 320 at Ball State University during the spring of 2004.

The limitations of such a decision are certainly relevant to a discussion of the study’s external validity. The sample is not as diverse, in many aspects, as a more formal study would require. In addition, opinions expressed in the survey may have been influenced by course content and/or environment, as all respondents were exposed to relatively the same materials and class discussions.

However, as an informal collection of respondent’s views used for the purpose of demonstrating how a larger study could possibly be administered, the sample can be useful if conclusions are drawn about this particular group’s responses and not generalized to include the whole of the 18-24 year old market. It’s obvious that the development of messages relevant to this entire age group should be backed by extensive research, on a much larger scale, of the thoughts of young adults.
The current challenge, then, becomes identifying the message most relevant to these particular Marketing 320 students, as members of the 18-24 age group. Several research questions become relevant as different techniques are examined.

- Do obese people tend to be of a particular personality type?
- Do young adults have a significant fear of death?
- Are young adults concerned with their quality of life in the years immediately preceding death?
- How informed are young adults about the effects of obesity?

The questionnaire administered was primarily an original creation, but some of the research questions demanded greater expertise and existing scales from the social sciences. (See Appendix A)

An online personality test was administered and respondents included the results in their survey information. This test is available online at the following URL: http://users.wmin.ac.uk/~buchant/wwff/. This test is based on the Five Factor Model of Personality and contributes to research being conducted through the University of Westminster in the UK. Respondents are scored in five independent factors (extraversion, agreeableness, conscientiousness, neuroticism, and openness) and their scores ranked as "relatively high," "about average," or "relatively low," indicating their tendency to exhibit that factor, based on a relative measure of the individual's scores compared to the scores of other respondents. In 2001 the site claimed to have 2,448 responses in its pool of data. Surely that number has reached more massive proportions in the last three years. Whether
or not that additional data is included in the calculation of current results cannot be concluded. (Buchanan 2001)

There are multitudes of publications concerning the measurement and effects of the natural human fear of death. Often referred to as 'death attitude' studies, several scales have been developed to measure how death affects our emotions, motivations and concerns. One of the most influential researchers in the psychology of aging, Dr. Victor Cicirelli, has developed the Personal Meanings of Death Scale, which provided ways to connect peoples' attitudes about death to their attitudes about behavior change.¹ One statement that later became a focus point was “Death is remote from everyday life,” implying that there's no connection between death and behavior change, so neither can act to effect each other. (1998)

The Collett-Lester Fear of Death and Dying Scale also provided a way to measure death attitudes, but focused on different types of fear, rather than the meanings of that fear, as in Cicirelli’s scale. The four areas measured by the scale include fear of death of self, death of others, fear of dying of the self, and fear of dying of others. Death represents the ceasing of human existence and dying focuses on the quality of life prior to actual death. The two most relevant to this discussion are those concerned with the death and dying of the self.² (Loo 1996)

The Fear of Death and Dying Scale provided an excellent bridge into research question three, concerning quality of life. In addition, the Anxiety About Aging scale

¹ See Appendix A: questions numbered 66, 67, 69, 71, 73, 75, 78, 80, 81, and 82 were adapted from Cicirelli's scale.
² See Appendix A: questions numbered 65, 68, 70, 74, and 77 were adapted from the Collet-Lester Fear of Death and Dying Scale.
proved useful as it measured factors indicating capabilities during elderly years. Specifically, the instrument measured respondents' attitudes toward losing the ability to function mentally, physically, and emotionally during the years immediately preceding death.\(^3\) (Lasher 1993)

These instruments, as viable psychological profiling instruments, have all been deeply researched and authenticated. However, they were utilized here merely for the purpose of idea generation and definition. By taking them out of the contexts of their original scales, they primarily serve here as background study about aging and death. As it is a prominent, developed science, researching aging and death psychology and the ways that human concerns are categorized helped to define the ability of fear to motivate human behavior.

It's clear, then, that the following survey and its results are very informal. However, as the research contained within this survey has been compiled purely for the purpose of developing an appropriate message for the pool of respondents, it remains valid. Its basis in social science theory may not include all aspects of these attitudinal scales, but all aspects are not relevant to the marketing discussion. Those factors that do provide interesting conclusions about message development include answers to the main research questions.

Once responses to the survey were recorded, a Chi-squared distribution was used to determine the statistical significance of the data with weight as the independent variable, in order to determine whether or not there were significant correlations between weight and

\(^{1}\) See Appendix A: questions numbered 72, 76, 79, and 83 were adapted from the Anxiety About Aging scale.
the attitudes and behaviors of the respondents. The sample mean of the dependent variables was used to build the matrix cells for the \(X^2\) calculations.

In total, forty five students participated in the survey, 17 (38%) of whom indicated (on a height/weight chart) that they fell into BMI categories of overweight, obese, or morbidly obese.

**Research Question: Do obese people tend to be of a particular personality type?**

In Marketing 320 classes at Ball State University during the spring of 2004, there was no significant correlation between weight and personality, as measured by the Five-Factor Personality Test.

Interestingly, however, the classes did have some strongly prevalent personality factors. Respondents to the survey showed higher than average conscientiousness and lower than average neuroticism. All other factors were rated among the average responses, as they were recorded on the Five-Factor Personality test web survey results.

**Research Question: Do young adults have a significant fear of death?**

Though most respondents agreed that they would avoid death at all costs, significant fear of death does not seem to be a factor in many of these students' minds. Notably, there was a significant correlation between weight and belief of the importance of living a long life. Nearly all standard weight respondents valued the importance of living a long life above the mean value, but overweight people were split evenly – half (plus one) valuing it as more important and half valuing it less.

Another interesting factor was the ability of death to challenge people to take risks. People in overweight categories resoundingly answered positively to the existence of this
effect, while standard scaled people were slightly split to the negative response. Overweight people in this sample are challenged by death. Never knowing when it will strike, these people seem to have committed themselves to enjoying what time they have.

The same distribution of beliefs appeared from analysis of the statement “Death makes me live to prepare for it.” Overweight people agreed with this statement, and standard weight people disagreed.

According to these results, it appears that overweight people think about death in a more eminent light than do standard weight people, who seem to see it as being a consideration for the distant future. But expected life lengths of the two groups offer an interesting quandary. There is a significant correlation between expected length of life and weight, but not what one would assume. Overweight people actually believe they will live longer than the average response, and standard people believe they will live shorter lives than the average response. Interesting, since the overall recognition that obesity is a dangerous disease will be noted in a further research question.

Research Question: Are young adults concerned with their quality of life in the years immediately preceding death?

The majority of respondents claimed not to consciously think about their quality of life that much, but when prompted, standard weight people were significantly more likely to respond that their physical health, up until death, is of great importance to them.

Most respondents were slightly scared of being disabled in their late years, and would be willing to eat healthier now if it would give them a better quality of life in their last three years. However, standard weight people value being healthy, in general, more
than do overweight people. As overweight people get older, though, they increasingly worry about their health more than do standard weight people.

Overall, it appears that this is not an easy attitude to measure and make generalizations about. Those who are not in need of weight control and behavior change are concerned with quality of life and their health. But those that would be the focus of any marketing messages are not concerned with them, and likely would not be motivated by messages appealing to such concern.

Research Question: How informed are young adults about the effects of obesity?

Respondents in this survey are very knowledgeable about the effects of obesity and many have committed themselves to taking steps that will avoid its onset. These students know that being overweight can contribute to early death, cause heart problems, and increase blood pressure.

As indicated earlier, this wide-spread knowledge about the effects of obesity does not affect overweight peoples' expectations of life length. Despite being overweight and at risk for many health problems, of which they are aware, these students still believe that they will live long lives, as compared to the beliefs of the other respondents. Perhaps this is indicative of their plans to make life changes, or perhaps they are cognizant of the fact that obesity can cause health problems, but not of the fact that this can be affected even at young ages. Further research is needed to determine the relationship between these two, seemingly contradictory conclusions.
Other Findings

In addition to answering the basic research questions, outlined above, some other correlations were also noted between weight and various factors.

First, those that are not in the overweight categories have given significantly more effort to staying that way. They exercise often, claim commitment to healthy eating, and put importance in being physically active.

The majority of all respondents stated that they watch carbohydrates, fat, and/or calories closely. They also have a collective belief that maintaining their recommended weight is difficult.

Overweight respondents were more likely to wish they were thinner, though even standard weight students were split nearly even on this factor. Again, a correlated but close factor was thinking about weight – overweight people are more likely to ponder it, but even half of the standard weight people tended to think about it more than the norm.

Other factors deemed important by all respondents were success related, which may have been due to the sample having been drawn from a university population. No matter what the reason, this population, no matter what their BMI, is highly concerned with the importance of their future job, being well liked, and having good romantic relationships.

Research Findings and the Transtheoretical Model

All of these factors, when combined, should give an idea of where this population falls within the Transtheoretical Model of behavior change and what types of messages will best motivate them to move further along the progression of the model.
As the Transtheoretical Model also accounts for those who have not yet recognized a problem in themselves, all members of this population will fall somewhere in the spectrum. Even those who are currently at a standard weight will be, at some point in their lives, responsible for influencing someone else, whether it is a child, co-worker, or parent. For this reason, no one should be ignored when attempting to better approach the obesity problem. It is far reaching and only a complete social change will create the supportive environment necessary to turn the problem around.

Easily, then, those respondents in the standard weight categories that do not think about their weight or wish to be thinner can be placed in the Pre-contemplation stage of the model. They are highly aware of the obesity problem, but have not realized a personal connection with it.

The rest of the survey population – the standard weight people who still wish to be thinner, and the overweight people that all think about their weight and wish to be thinner – can be placed in the Contemplation stage of the framework. They know the effects of being overweight, have recognized it in themselves (correct or not) and are now beginning to contemplate behavior. They are not yet committed to making a change.

That is where social marketing comes in. Influencing the behavior change of these people is the goal of any marketing effort focused on the obesity problem. In this case, marketing efforts should be focused on motivating these people to move from Contemplation into Preparation. The main leap between these two phases is the commitment to make a change and to act accordingly. Getting this commitment is the key.
As discussed in a previous section of this report, the types of marketing messages most successful in moving people between these two stages are those focused on creating greater benefit in the contemplation of change. The current challenge is that contemplators have previously valued the pleasure of the behavior over the benefit of change. For this reason, their concerns are based on how to accomplish their goals and be successful.

Self-efficacy, or belief in one's ability to accomplish, is one of the main issues in social marketing. Often tactics like modeling can provide this needed nudge in self confidence. In this case, the personalities of respondents were heavily conscientious, and they may be approached by appeals to their sense of responsibility.

Overall, it does not appear that fear messages about death and quality of life should be employed, as there is no significant evidence that people in this age group think about these factors often. In addition, fear messages do not add to the immediate value of behavior change. The may serve to detract from the enjoyment of overeating, but the general consensus of the information presented for this population is that the immediate future is more important than the distant.

These students are highly concerned with their quality of life in the next five years, which they surely believe will be a determining factor in their quality of life from years 75-80. The social and personal stress of this age group leads its priorities to more immediate manifestations, such as relationships, friendships, and careers.
Limitations and Conclusions

The largest limitation of this study is its reliance on college students as a sample. The percentage of overweight people, focus on success, and conscientious personalities are all greatly influenced by the sample's background, which would vary more if the sample were more diverse.

Thus, further research is needed to determine the wide-spread effects of fear and quality of life messages on young adults. Specifically, a larger sample size, more reliable method for recording personality profiles and weight sectors, and a more diverse sample would validate findings in a more formal study.

Through examination of the obesity problem, past marketing approaches to solving it, social science methods of effecting behavior change, and message development within a small population, it is clear that there is hope out there for social marketing and advertising to have an effect on this widespread epidemic. Each year the obesity problem gets a stronger hold among American and other populations. If it is not approached expediently we run the risk of truly learning the meaning of 'survival of the fittest.' As the fattest, we may not be able to survive, and advances in medicine and health care may not be able to keep up with advances in burger joints and pizza parlors.

But society is capable of turning obesity around. It's merely a matter of convincing the influential doctors and lawmakers, and motivating change on an individual level. Being fat isn't just something to talk about anymore – it's something to change.
Appendix A:

Survey on Healthy/Unhealthy Behavior
Survey on Healthy/Unhealthy Behavior
This is a confidential, anonymous survey. Care has been taken to insure that there is no way to identify your answers with you. It is important that you answer all questions honestly.

Date and ID Code
Where it asks for birthdate (lower left-hand corner) please put April 28 04
Where it asks for identification, starting in column "A" write in the last three digits of your home [parent(s)] phone number followed immediately by the last two digits of your social security number.
   For example:
   Dad's phone number 555-4152
   My social security number 555-43-4637
   ID Code: 15237
   Fill in the bubbles under each digit.

Demographics
Please fill in the bubbles to record the following information.
1. Sex  (A) Female  (B) Male
2. Age  (A) 18-25  (B) 26-29  (C) 30-39  (D) 40-49
3. Major  (A) Marketing  (B) Interior Design/Fashion Merchandise  (C) Journalism/Advertising  (D) Telecommunications  (E) Other ______________

Five Factor Personality Test
Factor I  Extraversion
4. (A) Relatively High  (B) About Average  (C) Relatively Low
5. (A) <22  (B) 22-23  (C) 24-25  (D) 26-27  (E) 28-29  (F) 30-31  (G) 32-33  (H) 34-35  (I) 36-37  (J) >37
Factor II  Agreeableness
6. (A) Relatively High  (B) About Average  (C) Relatively Low
7. (A) <22  (B) 22-23  (C) 24-25  (D) 26-27  (E) 28-29  (F) 30-31  (G) 32-33  (H) 34-35  (I) 36-37  (J) >37
Factor III  Conscientiousness
8. (A) Relatively High  (B) About Average  (C) Relatively Low
9. (A) <22  (B) 22-23  (C) 24-25  (D) 26-27  (E) 28-29  (F) 30-31  (G) 32-33  (H) 34-35  (I) 36-37  (J) >37
Factor IV  Neuroticism
10. (A) Relatively High  (B) About Average  (C) Relatively Low
11. (A) <22  (B) 22-23  (C) 24-25  (D) 26-27  (E) 28-29  (F) 30-31  (G) 32-33  (H) 34-35  (I) 36-37  (J) >37
Factor V  Openness
12. (A) Relatively High  (B) About Average  (C) Relatively Low
13. (A) <22  (B) 22-23  (C) 24-25  (D) 26-27  (E) 28-29  (F) 30-31  (G) 32-33  (H) 34-35  (I) 36-37  (J) >37

Please turn to the back of the this sheet and continue.
Please fill in the bubbles to indicate the level to which you agree or disagree with the following statements. Try to answer each statement honestly and quickly.

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<th>Slightly Agree</th>
<th>Slightly Disagree</th>
<th>Strongly Disagree</th>
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<tr>
<td>14. I often eat when I am upset, stressed or depressed.</td>
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<td>15. I seem to be happiest when I am eating.</td>
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<td>16. I would dramatically change my lifestyle if it would extend my life from 75 to 80 years.</td>
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<td>17. I stop eating before I feel stuffed.</td>
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<td>18. Regular exercise is more important to be healthy then watching what I eat.</td>
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<td>19. I eat more calories on an average day than I should.</td>
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<td>20. Overweight people tend to have fewer friends.</td>
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<td>21. Being healthy is very important to me.</td>
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<td>22. Junk food is my life.</td>
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<td>23. I eat to live not live to eat.</td>
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<td>24. Unhealthy snack foods are my weakness.</td>
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<td>25. Living a long life is important to me.</td>
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<td>26. People are surprised how little I eat.</td>
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<td>27. Being overweight will cause health problems in the later years of a persons life.</td>
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<td>28. I often think about how long I will live.</td>
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<td>29. I often eat less than three meals a day.</td>
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<td>30. My most enjoyable times involve eating.</td>
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<td>31. I don't pay much attention to what I eat.</td>
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<td>32. Overweight people tend to be happier than others</td>
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<td>33. If I were sure it would make the last three years of my life more enjoyable, I would eat healthier now.</td>
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<td>34. I have a very active &quot;sweet tooth.&quot;</td>
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<td>35. I am always eating when I am with friends.</td>
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<td>36. I often eat more than three meals a day.</td>
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<td>37. Being overweight will contribute to an early death.</td>
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<td>38. I watch my calories and/or fats and/or carbs closely.</td>
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<td>39. I have seriously thought about my &quot;quality of life&quot; at the last few years of my life.</td>
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<td>40. Overweight people have a hard time developing a romantic relationship.</td>
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<td>41. I exercise often.</td>
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<td>42. Being physically active is important to me.</td>
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</table>
43. Being physically healthy until shortly before my death is important to me.

44. I am committed to eating healthy food.

45. It would be hard for me to change my eating habits for an extended period of time.

46. At meals, I generally eat more than a normal amount.

47. Overweight people have a tougher time getting advancing in their career than others.

48. Being overweight seldom causes high blood pressure.

49. Having a good romantic relationship makes life more enjoyable.

50. Being well liked by others is important to me.

51. If I had my wish, I would be thinner.

52. Being overweight will cause heart problems later in life.

53. Maintaining my recommended healthy weight would be difficult for me.

54. Being physically disabled when I am old scares me.

55. Having a job, with a future, that I enjoy is important to me.

56. I think about my weight often.

Just a few more questions.

57. How muscular is your body?
   (A) very muscular (B) muscular (C) somewhat muscular (D) not muscular

58. On the average, how often do you exercise in a week?
   (A) 0 (B) 1 (C) 2 (D) 3 (E) 4 (F) 5 (G) 6 (H) 7

59. On the average, how long do you exercise each time?
   (A) <1/2 hour (B) 1/2 hour - 1 hour (C) more than1 hour, less than 2 hours (D) 2 hours or more

60. On the average, what is the intensity of you exercise?
   (A) Hard exercise (B) moderate exercise (C) easy exercise

61. On the weight chart, I fall in the following block. (A) I (B) II (C) III (D) IV

62. I expect to live to the following age.
   (A) 60-65 (B) 66-70 (C) 71-75 (D) 76-80 (E) 81-85 (F) 86-90 (G) Over 90

63. I expect my "quality of life" for my last three years to be...
   (A) great (B) good (C) okay (D) not so good (E) bad

64. In the last two years I have seen ads about the problem of being overweight. I have seen
   (A) no (B) a few (C) several (D) many

If you have seen any ads, please list the problems of being overweight or the benefits of losing weight which you recall being mentioned in the ads. You may record your answers on the blank sheet. Thank you.
| Height ("') | 4'10" | 4'11" | 5'0" | 5'1" | 5'2" | 5'3" | 5'4" | 5'5" | 5'6" | 5'7" | 5'8" | 5'9" | 5'10" | 5'11" | 6'0" | 6'1" | 6'2" | 6'3" | 6'4"
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Survey on Healthy/Unhealthy Behavior (Part Two)

Date and ID Code

Where it asks for birthdate (lower left-hand corner), please put April 28 04
Where it asks for identification, starting in column "A," write in the last three digits of your home [parent(s)] phone number followed immediately by the last two digits of your social security number.

For example:
Dad's phone number 555-4152
My social security number 555-43-4637
ID Code: 15237

Fill in the bubbles under each digit.

Please fill in the bubbles to indicate the level to which you agree or disagree with the following statements. Try to answer each statement honestly and quickly.

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<th>Slightly Disagree</th>
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Resources


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