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## **Abstract**

### **Purpose**

Social marketing is used to identify and change behaviours within a segmented audience. The approach uses theoretical insights, and an appreciation of an individual's environment and to understand and suggest approaches to change behaviours. This study explores the costs and benefits that young adults perceive to be associated with adopting healthier food, alcohol and physical activity behaviours.

### **Design**

Focus groups were conducted between April to August 2007 with a sample of 54 young adults aged 19-24 years, from the North East of England. Qualitative thematic analysis was undertaken using Nvivo software.

### **Findings**

Young adults recognise future health benefits that they could gain from following healthier lifestyle behaviours, however, at their present age their focus is on benefits such as weight regulation and improving one's appearance. External competitive forces act against these benefits and result in time and effort costs associated with accepting the proposition of healthier lifestyle behaviours.

### **Originality/Value**

This paper adds to limited research which has been conducted at the time of 'emerging adulthood', the period of 18-25 years of age. This is despite this being an opportunistic moment in young adult's lives to encourage them to adopt healthier lifestyle behaviours. Given these results, health messages may need to be reframed to better account for the benefits and costs that young adults associate with healthier lifestyles.

## Introduction

Social marketing is used to tackle a wide range of public health issues, such as encouraging smoking cessation, reducing binge drinking, and increasing engagement in physical activity (Peattie and Peattie, 2009). Social marketing has been defined in many ways, but is usually taken to mean “... a strategic or planning process, or systematic application of techniques, used for the benefit of individuals or society rather than commercial gain” (Carins and Rundle-Thiele, 2013, p. 1629). In this way, social marketing is used to enact healthy behaviour change, in anticipation of individuals receiving a future health benefit (Brocklehurst *et al.*, 2009). Social marketing is a framework which utilises benchmark criteria (Brocklehurst *et al.*, 2009). These eight criteria should ideally be considered when planning a social marketing intervention, and are labelled: customer orientation, behaviour, theory, insight, exchange, competition, segmentation, and methods mix (Gracia-Marco *et al.*, 2011). These criteria prompt a focus on understanding a segmented target audience; using theoretical approaches to focus on changing specific behaviours; understanding individual motivations and their costs and benefits to changing behaviours; identifying barriers that could hinder behaviour change; and using an array of marketing methods to facilitate behaviour change (Gracia-Marco *et al.*, 2011). In public health, social marketing attempts to generate a behaviour (health) proposition that individuals will favour, and aims to create a dialogue between health professionals and individuals to facilitate behaviour change (Peattie and Peattie, 2009). Social marketing can also be used by policy makers, health professionals and organisations to enact upstream and downstream change (Stead *et al.*, 2007b).

Social marketing has been used extensively in the USA, promoting fruit and vegetable consumption, breastfeeding and physical activity (Grier and Bryant, 2005); although there is less evidence of its use in the UK and Europe (Stead *et al.*, 2007a). The initially limited UK evidence base for the use of social marketing to improve (multiple) health behaviours may be due to the initial absence of a clear definition of social marketing, together with a lack of a clarity as to how social marketing was done in practice (Stead *et al.*, 2007b). The more limited evidence base in the UK can also – arguably – be traced back to a slow build-up of momentum of the role that social marketing could play in improving health (and other) issues (Andreasen, 1994). That said, where social marketing has been adopted worldwide, it

has been shown to be effective at helping improve individuals' dietary and alcohol behaviours, and reduce tobacco and illicit drug use, often tackling individual behaviours, rather than through a holistic approach however (Gordon *et al.*, 2006b; Gordon *et al.*, 2006a; Truong, 2014). By voluntarily engaging with individuals, social marketing does not coerce people into behaviour change, it helps them to see why changing their behaviours benefits them (Gordon *et al.*, 2006b; Gordon *et al.*, 2006a). One of the key elements to social marketing is that it explores what may be stopping individuals from changing their behaviours by looking at individual's immediate environments including the influence of friends and family, alongside the influence of their wider economic, social and cultural environments (Hastings *et al.*, 2000). By gaining an insight into what individuals value, by promoting a healthful environment and utilising theory to design social marketing interventions (Carins and Rundle-Thiele, 2013), successful behaviour change has been achieved (Department of Health, 2008). It is increasingly being recognised that social marketing needs to counteract commercial marketing that promotes unhealthy behaviours (Stead *et al.*, 2007b). It also needs to go beyond educating people about why they should be healthy, given that individuals do not tend to listen to such messages (Peattie and Peattie, 2009). By making better use of the methods mix (Luca and Suggs, 2013), individuals can be encouraged to change their behaviours and not just their attitudes and intentions (Donovan, 2011).

We argue that two particular social marketing criteria are crucial when fostering behaviour change, namely exchange and competition. Exchange has its roots in economics and psychology and is one of the fundamental assets of marketing (Hastings and Saren, 2003; Thackeray and McCormack Brown, 2005; Rothschild, 2009). As such, translating the fundamental marketing element of exchange for a social marketing purpose, involves an exchange of values (Hastings *et al.*, 2000), which are accepted by both parties in a voluntary capacity (Dann, 2010). It involves creating a desirable behaviour proposition in such a way that the target audience can assess the exchange involved, the benefits and costs associated with changing their behaviours (Andreasen, 2002), which may include material exchanges (e.g. having to pay to attend exercise classes) but also social exchanges (e.g. choosing not to attend a social gathering to avoid consuming alcohol) (Andreasen, 2012). Ideally, and in order to enact change, the benefits of changing behaviour need to be perceived as

outweighing the costs associated with adopting the behaviour proposition. Fundamentally, the process of exchange occurs as individuals seek to maximise their self-interests, by increasing the benefits they receive from a given behaviour whilst minimising the costs involved (Grier and Bryant, 2005). To attain these benefits they need to be convenient and easy for individuals (Andreasen, 2002). This ease and convenience of achieving a beneficial exchange is particularly important as social marketing is often competing directly and indirectly with many commercial and other influences which can hinder behaviour change (Hastings and Saren, 2003; Thackeray and McCormack Brown, 2005). Ultimately 'value co-creation' is needed; meaning active engagement with a variety of stakeholders for mutual benefit (Lefebvre, 2012).

As part of the behaviour proposition, the associated costs and benefits are exchanged by individuals, including tangible/financial costs and benefits, but also intangible costs and benefits (e.g. psychological impacts); both of which play an important role in behaviour change. These form an ultimate 'price' that has to be paid, which is "the cost or sacrifice exchanged for the promised benefits" (Grier and Bryant, 2005, p. 323). Individuals will seek the greatest benefit for the lowest cost when they are considering changing their behaviours (Grier and Bryant, 2005; McDermott *et al.*, 2005). This is of course a rational outlook, yet is made more complicated when considering that often the benefits associated with changing behaviours are often delayed (i.e. accrued later in life), in comparison to immediate costs and barriers (Grier and Bryant, 2005; McDermott *et al.*, 2005; Gordon, 2012). As a social marketer, there needs to be promotion of the benefits and downplaying of the costs, to create a favourable proposition; bearing in mind that costs and benefits should be considered from the perspective of the target individuals and not from the perspective of the social marketer (Thackeray and McCormack Brown, 2005; Noble, 2007).

Contributing to the costs associated with the behaviour proposition is the notion of competition and competitive forces. Competition, is again, another fundamental component of marketing that has been transferred across to social marketing (Grier and Bryant, 2005). It originally involved meeting the needs and wants of customers better than the competition (Peattie and Peattie, 2003), yet has since expanded to encompass the external forces that compete against healthy choices and behaviours in a public health

context (Noble, 2007). Sources of competition can include: other individuals, marketing of unhealthy foods and a lack of availability and/or access to healthy food. Minimising these competitive forces, or creating strategies so that the individual can circumnavigate or remove these competitive forces, is a crucial component of social marketing (McDermott *et al.*, 2005).

Together, the notion of exchange (a cost-benefit approach), and forces of competition are at the crux of social marketing. This paper will explore these three impacting factors associated with the behaviour proposition of following lifestyle advice and initiating healthier lifestyle behaviours, in a sample of young adults aged 19-24 years from the North East of England. The competitive forces acting against the behaviour proposition and the barriers preventing engagement in healthier behaviours will be explored, alongside the benefits which encourage young adults to adopt the exchange transaction and healthy behavioural change. Identifying these factors will help to better-design behavioural interventions with these young adults.

This study purposefully focuses on the three behaviours of food, alcohol and physical activity as opposed to only one of these behaviours. The rationale behind this decision was routed firmly in the logic that all three behaviours are central to a healthy lifestyle (for example, energy balance maintenance). Despite this explicit association only a very limited number of studies have attempted to explore this interplay with any population groups including young adults. Where research does focus on these interlinked behaviours it has been predominantly USA centric (Simoes *et al.*, 1995; Anding *et al.*, 2001; Bryant *et al.*, 2012), meaning the findings are not directly transferable to a UK setting (Giles and Brennan, 2014). Additionally, by focusing on all three behaviours, we strongly believe that the resulting data is better grounded in everyday life – that is, young adults engage in multiple behaviours each day (Simoes *et al.*, 1995). In particular, recent work has shown that young adults regularly trade between these three behaviours when trying to engage with healthier lifestyles (Giles and Brennan, 2014). Essentially, and in the context of healthier lifestyles, these behaviours are not enacted in isolation from each other. Only by looking at all three behaviours is it possible to examine the behaviour proposition in full, by looking at the multiple components that make-up a healthy lifestyle and the decisions and actions that

young adults make to achieve (or not) a healthy lifestyle. We recognise that this imposes limitations such as breadth rather than depth, but given a lack of literature in this area and the inescapable association of the three behaviours for energy balance maintenance as part of a healthy lifestyle, this exploratory research seeks to highlight issues that can be studied in-depth in future research and critically engage with the methodological challenges associated with undertaking such a holistic lifestyle study.

## **Methodology**

This exploratory study used focus groups to identify the costs and benefits associated with adopting healthier lifestyle behaviours. Newcastle University Ethics Committee approved the study and all participants provided their written consent for their data to be used in the research. In total, twelve focus groups were held during April to August 2007 with 54 young adults (conducted by ELG) until data saturation was achieved. Participants were recruited via recruitment notices placed in supermarkets, sure start centres, libraries and supermarkets across the North East of England. Additionally, an email was sent to Newcastle City Council employees and Newcastle University staff and students. Snowball and convenience sampling was used to recruit participants once initial interested individuals had contacted the researchers. In order to focus on a segmented audience, in line with a social marketing approach, we targeted 18-25 year old young adults (although only individuals aged 19-24 years volunteered to participate in the study). The recruitment notices asked for employed, student and unemployed participants in this age group. It could be argued that this age range constitutes a large segment given that this is a time point when young adults can potentially engage in a number of new behaviours. These behaviours include moving away from home for the first time, starting university or a new job, cohabiting and even starting a family (Shanahan, 2000; Devine, 2005; Umberson *et al.*, 2010). However, the literature recognises this age group as a distinct population segment; known as “emerging adulthood” (Nelson Laska *et al.*, 2010; Nelson *et al.*, 2012) and as such we chose to focus on 18-25 year olds. We did not purposefully recruit based on set socio-demographic characteristics aside from aiming to achieve a balance between genders and between students and those who were employed (unfortunately no unemployed individuals volunteered for the focus groups, and whilst we contacted local job centres to ask if we could place recruitment notices on their notice boards, we were not granted permission).

The focus groups varied in size between three and seven participants. The most common group size was four participants, often as a result of non-attendance by those invited to particular focus groups. That said, smaller group sizes are not uncommon (Bloor *et al.*, 2001; Bryman, 2004), and are often used when in-depth accounts are required (Cronin, 2008). Heterogeneous and homogeneous focus groups were conducted where appropriate. Heterogeneous focus groups were held if the participants were part of a shared friendship group, to ensure participants attended and felt comfortable discussing the topic. In terms of recruitment, often one individual volunteered for the research and then recommended their friends. In these cases, the friendship group was maintained. Homogenous groups were also conducted to ensure that the views from the same gender (male or female) and same occupation (student or employed) were captured; and allowed them to explore common ground arising from shared characteristics (Flick, 2002). The focus group discussion guide explored opinions and attitudes towards: 1) the types of foods and alcoholic drinks the young adults consume and their participation in physical activity; 2) what they think about healthy lifestyle behaviours in a general sense, and what influences their particular behaviours (i.e. costs and benefits); 3) where they would seek advice on a healthy lifestyle and why; 4) recommendations for leading a healthy lifestyle; and 5) future behaviour change. All focus groups were audio recorded and verbatim transcribed. The transcripts were analysed (by ELG) using NVivo 7 QSR International software (checked by a second researcher (MB)), using both 'in vivo' and sociologically constructed thematic coding (Flick, 2002; Strauss, 2003). All participants were provided with a £20 shopping voucher to cover their travel costs.

We adopted an inductive approach akin to grounded theory, and a deductive approach (using an analytical framework), taking care not to a priori determine classifications, theories or socio-demographic characteristics, and as such we did not recruit participants based on these categories. Instead, we took a stance that privileged reported attitudes and behaviours rather than predetermined classifications. That said we did analyse and present the findings using an analytical framework. This framework was inspired by the literature review surrounding social marketing and the idea of a behaviour proposition and the associated exchange of related benefits and costs (see Figure 1). As the behaviour

proposition is grounded in best practice recommendations for a healthy lifestyle in relation to food, alcohol and physical activity, there are essentially three sub-propositions. In terms of food, the sub-proposition is to eat a healthy, balanced diet in order to achieve and maintain a healthy body weight (NHS Choices, 2014). The physical activity sub-proposition focuses on being active for a minimum time and intensity each day in order to stay healthy (NHS Choices, 2011). In terms of alcohol consumption the sub-proposition focuses on individuals regulating the amount of units of alcohol that they consume in order to lower the risk to health (Change4life, 2014). Together, if young adults adopted the behaviour proposition to be healthy across their food, alcohol, and physical activity behaviours, they would have a reduced risk of developing lifestyle-related illness (e.g. obesity, diabetes) associated with the over-consumption of food and alcohol and engagement in limited physical activity. In particular, the proposition focuses on encouraging young adults to establish behaviours that are in line with guidelines on food, alcohol and physical activity (see Department of Health, 1991; Gill, 2002; The Information Centre, 2008; Peattie and Peattie, 2009; World Health Organisation, 2013).

The framework proposes that in order for young adults to engage in healthier behaviours they need to see the benefits from engaging in healthier behaviours, i.e. the 'behaviour proposition'. The exchange between the benefits and the costs needs to result in the benefits being more highly valued than the costs of engaging in healthy behaviours and stopping unhealthy behaviours. Should they immediately reject this exchange, they would continue with their current food, alcohol and physical activity behaviours and reject the behaviour proposition. However, they may decide to evaluate the proposition further. This evaluation would involve further weighing the bundle of benefits that they would receive should they accept the behaviour proposition (e.g. enjoyment), but would be complicated by the potential for the young adults to incur costs from adopting the proposition of healthier behaviours (e.g. time, money or effort required). By weighing up these costs and benefits they may decide to fully engage with the behaviour proposition (i.e. adopt healthier food, alcohol and physical activity behaviours), moderately adopt their behaviours, adopt limited new behaviours, or reject the proposition and remain with the status quo. Only when the young adults perceive the benefits to outweigh the costs will they seek to change their lifestyle behaviours. That said, there are further external competitive forces that



further impact on the assessment of the behaviour proposition and further contribute to the exchange between the benefits and costs that the young adults face – i.e. the time, money, or effort that would need to be ‘spent’ in order to overcome these external competitive forces (see Figure 1 for a diagrammatic illustration of this framework).

[Insert Figure 1 here]

This framework is used to illustrate the results of this study and helps to present and discuss evidence of how the young adults in this sample valued the ‘healthy lifestyle’ proposition, and the accompanying costs and benefits that hinder them from adopting healthier food, alcohol and physical activity behaviours.

## **Results**

In total, 54 young adults took part in the focus groups. Of these, the majority were students (n=39) and the remaining participants were employed (n=15). In terms of gender, the majority of participants were female (n=36) compared to male participants (n=18). In terms of age, seven participants were aged 19 years; 12 aged 20 years; 10 aged 21 years; nine aged 22 years; 10 aged 23 years; and six aged 24 years. The majority of individuals (n=42) reported their marital status as single; seven reported ‘living with partner’; and five were married. Finally, 23 individuals reported living with their friends; 13 with their family; nine with a partner/husband/wife; six with flatmates; two in a mixed household; and one individual lived alone. In order to reduce participant burden, and because we did not want to presuppose results were related to predetermined socio-demographic characteristics, we did not collect data on other demographic criteria such as whether the participants had children of their own. We have analysed the results based on gender, age and employment status and found that the results did not vary according to these particular socio-demographic characteristics.

To present the focus group results in relation to the analytical framework in Figure 1, verbatim quotes are provided below focusing on discussing: 1) participants understanding of the behaviour proposition, 2) the benefits and facilitators identified, 3) the competitive forces and resulting costs, and 4) level of acceptance of the behaviour proposition.

### *An understanding of the behaviour proposition*

In terms of the behaviour proposition – adopting healthy lifestyle behaviours – young adults need to be aware of lifestyle recommendations, understand them, and see them as personally relevant and achievable. However, when asked about recommended food, alcohol and physical activity guidelines (for details on these guidelines please see: Department of Health, 1991; Department of Health, 2006a; Department of Health, 2006b; Alcohol Concern, 2009; Giles, 2010; Giles and Brennan, 2014), the young adults held variable knowledge of, and attitudes towards, them. For example whilst a minority of the young adults took a keen interest in maintaining a healthy lifestyle by actively applying the guidelines, the majority were unaware of food, alcohol and physical activity guidelines:

*“I don’t know them, I just know that you have to eat fruit and vegetables that sort of thing...”* [FG290507008]

They said they found it difficult to interpret the guidelines in relation to their own behaviours and struggled to prioritise which guidelines they should be paying attention to. This meant only a few of the young adults put any effort into deciphering the guidelines and incorporating them into their lifestyles:

*“It’s [about] knowing which kind of ones to pick 'cause a lot of them are so conflicting.”* [FG050607011]

Taking physical activity as an example, few were undertaking moderate intensity physical activity five times per week, partly because they were unaware of and/or did not understand what was meant by moderate physical activity:

*“I thought you were meant to do about half an hour’s exercise three times a week, I’m not sure.”* [FG020507005]

*“I don’t have a clue to be honest with you...”* [FG170507007]

They were knowledgeable about alcohol guidelines; however some confirmed that they choose to ignore them:

*"...the alcohol warning's, I think it's something like four units for a man and to be honest with you it's ridiculous... I just don't think it's practical."* [FG060607012]

While there was widespread knowledge of the 5-a-day fruit and vegetable dietary advice, there was great uncertainty surrounding other dietary guidelines:

*"I only know five veg[etables], five fruit, two litres of water and for women twelve hundred calories."* [FG100507004]

*"I know that pyramid where it's fat at the top and is it carbohydrates at the bottom and then protein. But I don't know which foods are in which groups."* [FG040507006]

Thus, not always were the young adults choosing to ignore lifestyle guidelines; at times they were confused or unaware of what was recommended for a healthy lifestyle. In particular, some of the young adults stated that they found them overly restrictive, and that it was 'impossible' to meet all of the recommendations.

*"So many of them. They just, if you try to follow them all I think you'd probably end up dead."* [FG05060711]

How credible and serious the young adults perceived the behaviour proposition (i.e. that a balanced lifestyle can help reduce the likelihood of developing non-communicable diseases and aid weight maintenance) partly depended on whether they thought the source of the information was credible. There was also a view that multiple messages emphasising why individuals should be healthy were contradictory. 'Conflicting advice', from multiple messages, was considered to add to their confusion surrounding the behaviour proposition. In addition, some of the young adults thought that they should be left to their own devices, and should not be told to or forced to follow healthy guidelines.

*"Depends where it comes from. Like if it's not from an interested party, like the government"* [FG010607009]

*"But they say everything's bad for you, eating's bad for you, exercise's bad for you, so what do you do?"* [FG04060710]

*"...a lot of it is kind of force fed a bit too much and I think people might say it's better to make their own mind up on these things."* [FG05060711]

Finally, in terms of the behaviour proposition, the young adults did not always think that public health messages and guideline recommendations were there to help individuals to be healthy. There were some young adults who held almost conspiratorial views, that the recommendations were there so that there would not be a backlash from individuals saying that they were not informed of the negative consequences of an unhealthy lifestyle. There was also a view that the proposition was promoted in order to create a healthy workforce; so for economical rather than public health reasons. On the other hand, it was often viewed as advice so that savings to the NHS could be made from not having to treat lifestyle-related diseases.

*"By trying to encourage people to. It's sort of I think a lot of it is just trying to save themselves really 'cause they're just trying, trying to save themselves when people turn round and say well you didn't tell us this and it's your responsibility to tell us this."* [FG010507004]

*"I, personally, I think it's about maintaining a healthy workforce at the end of the day, that's all, that's all that they care about."* [FG060607012]

*"It's gonna help them in the long run if they're seen to be trying to promote something like that."* [FG290407003]

### *Benefits and facilitators*

Beyond their knowledge of what a healthy lifestyle is, the young adults were asked to discuss the benefits that they thought they would gain as a result of adopting the behaviour proposition (i.e. the benefits of being healthy), and factors that would facilitate this. A range of benefits were identified which included primary benefits of better skin through reduced consumption of sugary drinks, and increasing/diversifying socialising opportunities as a result of doing physical activity with other people. Other people also help facilitate healthy behaviours by: *“spur[ring] each other”* on.

Improvements in one’s physical appearance, by engaging with healthier behaviours, was directly linked to being able to regulate weight, and was perceived as a main benefit:

*“I’m very conscious of like body image and stuff...”* [FG020507005]

*“That’s probably my main reasons, going too much overweight for my liking and then doing something about it by going healthy.”* [FG0100507004]

The regulation of weight and associated improved appearance were also seen to help increase confidence from leading a healthier lifestyle:

*“Yeah you do feel better about yourself ... If you’re up and about you are wanting to do more and you do feel better in yourself. You’ve got more confidence I think as well.”* [FG290407003]

In addition, one of the main benefits to be identified was experiencing enjoyment and personal gratification from engaging in healthier behaviours:

*“I really enjoy so like starting doing er tykwando and martial arts coaching qualifications, fitness qualifications and stuff er so I can like do it as part of my lifestyle.”* [FG010607009]

*“... cooking your own meal on a night is something that I really enjoy and it’s encouraged me to sort of buy fresher stuff to you know what I mean to try and really make something on an evening.” [FG010607009]*

These benefits (including improved appearance, weight regulation and enjoyment) were all ones that the young adults said that they value from adopting healthier food, alcohol and/or physical activity behaviours. In addition to these present benefits, one particular future benefit was also identified. This benefit was maintenance of good health, should healthier lifestyle behaviours be adopted in the future:

*“...feeling good about yourself, instead of being, just feeling rubbish and feeling ill and feel like your bodies full of crap.” [FG170507007]*

*“I think ... to be healthy to sort of avoid all the sort of diseases and sort of erm physical distress.” [FG08060713]*

These benefits determined whether or not healthy food, alcohol and physical activity behaviours were followed by the young adults in the present, and potentially, in the future. That said, their ability and desire to be healthier was further complicated by external competitive forces, which can act as barriers to the young adults adopting healthier lifestyle behaviours.

#### *Competitive forces and resulting costs*

The young adults identified a range of competitive forces that hinder them from being healthier. These forces (can sometimes) impose costs onto the young adults, in terms of them having to spend time, money or effort on avoiding, circumnavigating or overcoming these competitive forces to ensure their lifestyle behaviours become or remain healthy. On analysis, these competitive forces were found to be in line with Andreasen’s (1995) (Andreasen, 1995) framework, of apathy, involuntary disinclination, social discouragement and counter marketing, and as such this framework is used to present these results.

Apathy is concerned with a lack of motivation to engage with healthier lifestyle behaviours.

It is rooted in the young adults not possessing an inclination, motivation, dedication or the impetus to exert effort and/or willingness to engage in healthy lifestyle behaviours (Andreasen, 1995). For many of the young adults the idea of putting any effort into their lifestyle behaviours was not something that they wanted to do. For instance, whilst some experienced a desire to be healthier in their food intake or participate in physical activity, this was overshadowed by it being easier to prepare less healthy foods and not do any physical activity. When reflecting on the behaviour proposition, of being healthier in their food, alcohol and physical activity behaviours, many of the young adults were dismissive of the implicit requirement to dedicate more time, financial and energy resources in order to accept the proposition:

*"I'm not very disciplined and [if] I've decided that I can't be bothered then I won't"*  
[FG230407002]

*"I could have a healthy lifestyle... but even then I can't be bothered half the time."*  
[FG170507007]

Ultimately the young adults were happy with many of their lifestyle behaviours, and even if they were unhappy with some of their behaviours, they indicated that it would be too much effort to change these behaviours, and this effort was too high a cost to pay to be healthier:

*"And you know that going out drinking's bad for you but you're gonna do it anyway, because you've always have done it and you've formed a pattern ..."*  
[FG010507004]

*"I do absolutely no exercise at all... I've been thinking about it and I need to start like now, I've been telling everybody, 'cause I'm in a terrible habit."*  
[FG0230407002]

Involuntary disinclination is shown by some of the young adults: 1) classifying themselves as 'fussy eaters'; 2) not liking particular foods and/or having the perception that healthier foods would not be liked; and 3) self-styled addiction to certain unhealthy foods or drinks.

These all hindered them from adopting healthier dietary behaviours and ultimately impacts on their overall lifestyle choices:

*"It's horrible because everything that's bad for you ... and everything that's good for you just tastes boring."* [FG0050607011]

*"...It's like you could be really healthy but you might be a bit miserable."*  
[FG060607012]

Social discouragement manifested itself in peer pressure, social norms, and general discouragement (Andreasen, 1995) (Andreasen, 1995). The influence of other people acted against some of the young adults' impulses to be healthier. For example, outright social discouragement resulted in many consuming less healthy foods when socialising with others. Being pressured to be less healthy than one would desire to be was evident in feeling the need to adapt one's food choices to accommodate household members, feeling the need to be polite which makes it difficult to turn down unhealthier food and alcohol offers, and over consumption of food and/or alcohol when socialising:

*"...if all the friends, all the friends are around your age always eating the unhealthy food, I think you will follow all they eat."* [FG020507005]

*"I think a lot of it sort of boils down to sort of peer pressure. I don't think I'd drink so much if it wasn't for the fact that it was a social sort of thing, you go out with your mates and you drink."* [FG080607013]

In particular, social discouragement to not alter alcohol consumption was evident. Here, young adults were influenced by others to maintain binge drinking behaviours, consume alcohol on nights out rather than soft drinks, and generally consume more alcohol than was recommended.

Additionally, it was acknowledged by many of the young adults that commercial counter marketing negatively influences them, as they are unable to resist temptation. This was said



to be a particular problem considering that the budgets of commercial organisations are significantly higher than the budgets available to promoters of healthy lifestyle behaviours (e.g. Change for Life, Department of Health initiative) and as such they are more aware of unhealthy foods and behaviours being advertised, eclipsing most attempts at promoting healthier food, alcohol and physical activity behaviours:

*“I think like the media and advertising and fast food and things like that. I mean and sometimes I just don’t have the ability to say no.” [FG020507005]*

*“But I’d say there’s just a lot of temptation around. Like it’s on adverts all the time and tele[vision] with all the offers on, like McDonalds, like you can get vouchers food or like twenty pounds worth of free food, so then you just go and eat it so that you can go and spend the voucher, because it’s free.” [FG290407003]*

*“It is, that, commercial marketing is so good because its had decades of money and research pumped into it in practice ...” [FG080607013]*

Overcoming such competitive forces requires a financial, effort and/or time investment (i.e. cost) that many young adults appear unwilling to make even given the acknowledged benefits discussed, and as such these competitive forces and costs have a significant impact on how young adults weigh up the balance of the costs and benefits associated with adopting healthier lifestyle behaviours. Additionally, because the young adults value the enjoyment that they gain from engaging in certain unhealthy behaviours, for example enjoying binge drinking with friends as a means to socialising, these ‘benefits’ also become a form of competition:

*“I suppose physically and psychologically you could make the argument that psychologically [you] maybe have more fun if you do things that are physically harmful to your body.” [FG060607012]*

As a result, those who wish to encourage young adults to be healthier must bear in mind that some of the benefits that the young adults gain from their food, alcohol and physical activity behaviours actually form a level of competition, in addition to the costs which will need to be overcome in order to support and facilitate them adopting healthier lifestyle behaviours.

#### *Level of acceptance of the behaviour proposition*

Having considered the behaviour proposition, the facilitators and benefits, and the competitive forces and resulting costs, some of the young adults indicated that they would be unwilling to engage with the proposition of healthier food, alcohol and physical behaviours at the present time in their lives, thus rejecting the behaviour proposition outright. They indicated that they enjoyed less healthy behaviours (e.g. binge drinking, consuming junk food) and that they did not want to lose something that they enjoyed by engaging in healthy lifestyle behaviours. That said, many of the young adults did acknowledge that they would be unable to continue with their unhealthy behaviours over the longer term, and indicated that they were likely to become healthier as they got older. They could see the long term benefit of leading healthier lifestyles, but felt that it was not necessary to change their behaviours in the short term as they would be able to accrue the associated long-term benefits of being healthy by making lifestyle changes at a later stage in their lives. At the present time, the young adults could not always see sufficient benefits to being healthy, which would outweigh the short term costs and competitive forces involved.

Moderate or limited acceptance of the behaviour proposition was acknowledged by some of the young adults given that they indicated that they were healthy in some of their lifestyle behaviours but not all; and/or that they would be willing to become healthier in some, but not all of their lifestyle behaviours in the future. Thus for example, they may engage in physical activity to counteract unhealthy food consumption and excessive alcohol consumption.

There was clear confusion around what is and is not healthy, a poor understanding of the guidelines on healthy food, alcohol intakes and physical activity recommendations, and difficulty interpreting the guidelines; yet outright rejection of the behaviour proposition was

rare, as most of the young adults had considered being healthy, had tried to be healthier in some of their behaviours in the past, or were trying to adopt healthier behaviours. Where they continued to be unhealthy it was due to a lack of enjoyment from being healthy or competitive forces and resulting costs that were too great to overcome.

Finally, in terms of the exchange involved, the young adults did not always perceive the same benefits and costs to those heavily promoted by public health campaigns. While they recognised the often-promoted benefits such as weight regulation and good health, they also recognised other benefits such as increasing one's self-esteem, lowering stress, improving mental health and wellbeing, and ageing well. Likewise, they recognised the often-promoted negative outcomes involved should healthy lifestyles not be followed, such as non-communicable diseases including obesity, but also viewed other negative outcomes to be important such as a lack of energy, poor dental health and being an unhealthy role model for others. Thus, it is argued that they perceived a wider range of benefits and costs to be important to them in the exchange process involved with the behaviour proposition than those explicitly communicated by public health campaign.

### **Discussion & Conclusion**

This study adds to a limited body of research detailing the inter-relationship between food, alcohol and physical activity behaviours in young adults aged 19-24 years in the UK. This exploratory research has found that young adults do not fully engage with the behaviour proposition of healthy lifestyles, due to an array of identified costs and competitive forces that outweigh the perceived benefits they see arising from adopting healthier food, alcohol and physical activity behaviours. This research has clearly identified that this age group – at a time of 'emerging adulthood' – perceive a variety of costs and benefits which are not always in accordance with those that are promoted in public health campaigns. In particular, the findings add to the body of knowledge on how young adults weigh up the exchange proposed by the behaviour proposition of adopting a healthy lifestyle.

In terms of the behaviour proposition of adopting healthier food, alcohol and physical activity practices, the young adults partially accepted the proposition. They indicated that they were either trying to adopt healthier food and/or physical activity practices, or would

do so in the future. However, they did not want to adopt healthier alcohol behaviours (e.g. reduce binge drinking episodes), which is consistent with previous research (Gill, 2002). Perceived benefits included wanting to feel fitter, lose weight and improve one's appearance. A focus on health as a result of an improved lifestyle was not a benefit that they saw as a current motivational factor for them; rather attaining good health was perceived as a future benefit. Where the young adults said that they would not engage with healthier lifestyle behaviours, it was not as a result of perceived financial costs necessarily, but rather perceived time and effort costs. The young adults said that they had a lack of time to engage in healthier behaviours, and in many instances could not 'be bothered' to adopt healthier behaviours, even if the benefits of doing so were perceived, a finding consistent with research in younger adolescents (Goh *et al.*, 2009).

Where the competitive forces and associated costs weighed greater than the benefits associated with the behaviour proposition, they said that they were not ready to change their lifestyle behaviours at the present time. Their lack of self-discipline coupled with an unstructured lifestyle meant that for many of the young adults they thought that it would be easier to change their behaviours at another time, i.e. in the future. They essentially thought that they could 'get away with' unhealthy behaviours whilst they were young, and could push back being healthier until they were older. This is classic optimistic bias (Gibbons *et al.*, 2010).

With particular reference to the benefits associated with the behaviour proposition – i.e. healthier food, alcohol and physical activity behaviours – these young adults perceived a wider range of benefits than those which are often-promoted in health promotional materials. For example, many generic public health messages promoting healthier lifestyles focus on benefits such as avoiding ill health (Kenny, 2012). Additionally, more well-known campaigns such as Change4Life do not even make it obvious how being healthy is relevant for young adults, focusing mainly on 'kids' and those who are 'middle-aged' (Change4life, \_). This may, in part, help to explain why these young adults are confused by, and/or do not engage with these health promotional campaigns as they see them as irrelevant to them and their current life stage. This, coupled with their acute awareness of commercial

marketing promoting unhealthy foods and alcohol drinks, combines to make an environment that is counter-conducive to healthier lifestyles (Kraak *et al.*, 2009).

Ultimately, these findings highlight four main implications. The first is a question of when is the best time to 'catch' young adults, so that they make healthier lifestyle changes. Whilst it could be argued that 'as soon as possible' is the answer to prevent tracking of unhealthy behaviours and weight gain from childhood into older adulthood (Lake *et al.*, 2009), a time period defined as 'emerging adulthood' - for those aged 18-25 years - seems particularly important. It is at this time point when many key transitions occur, including leaving home and starting a job. This could provide the 'perfect' opportunity to promote healthy lifestyles in workplaces and universities when young adults become more self-reliant and focus on asserting a new identity (Nelson *et al.*, 2012).

Secondly, since these young adults indicate that they are particularly unwilling to change their alcohol consumption behaviours, legislative action may be the only way to encourage more moderate alcohol intake in this group, such as with minimum unit alcohol pricing (Scalley, 2013).

Thirdly, given the success of commercial food marketing, counter-marketing may be needed to better promote healthier foods, drinks and physical activities, to shift the emphasis away from unhealthy products and sedentary activities (Block *et al.*, 2011). This may require health promoters to better market healthier products and lifestyles towards young adults, but may also require voluntary action by corporate food companies to ensure more responsible marketing of less healthful products (Story *et al.*, 2008). There have been substantial calls – and indeed some action – in terms of reducing marketing of unhealthy foods to children (Harris *et al.*, 2009). However, this action may need to be expanded to other population groups, if individuals – in this case young adults - find it difficult to ignore the pressure exerted by marketing activities to buy unhealthy products. Additionally, there may even need to be legislative action to control the marketing of unhealthy foods should companies not sufficiently – and voluntarily – reformulate their products or alter their marketing practices. Indeed, and learning from alcohol legislation, there may even be a case for a "health related food tax" (Mytton *et al.*, 2012, p. 1). As with taxation on alcohol, there

may need to be a tax on specific foods so that individuals (in this case, young adults) are deterred from buying unhealthy food products (or at least in their usual quantities). It is acknowledged however that this presents difficulties in practice, such as choosing which nutrients to target, the level at which a tax is set, how best to learn from the evidence base surrounding the effectiveness and acceptability of food taxes, and ensuring health inequalities are not exacerbated (Mytton *et al.*, 2012).

Fourthly, in terms of the exchange concepts mentioned by the young adults, they recognise a wider range of benefits and costs than is often promoted in public health communication. These wider benefits include for example ageing well, reducing stress and improving mental health. Considering these wider benefits, it may be the case that future public health messages need to recognise that this age group perceive a wide-ranging array of benefits linked to the behaviour proposition and actively promote these benefits in their campaigns. Likewise, these campaigns could also acknowledge the costs, benefits and sources of competition involved in the behaviour proposition which are particularly relevant to this age group, and better frame health communication messages to ensure they are salient to the lives of young adults. Certainly, this research suggests that there needs to be improved targeting of public health material to young adults in terms of the content, framing and messages, to better highlight the particular exchange elements (costs and benefits) that are perceived by young adults. By doing this, young adults may pay more attention to these messages, may better understand the messages as they would be framed within a context with which they recognise, and they may also be able to better relate to the messages and see why they should change their behaviours for reasons that they can identify with (Giles and Brennan, 2014).

Before concluding, we wish to highlight the limitations of our research. Firstly, we used convenience and snowball sampling and so the results cannot be generalised to all UK young adults. Secondly, as we did not recruit participants based on specific socio-demographic characteristics, some population groups are missing. In particular there are no unemployed individuals in this sample. Such characteristics - including gender, age and employment status - may influence attitudes and behaviours. Whilst we did not find that the results varied according to gender, age and employment status in this exploratory research, if a

larger sample was used, subtle differences may be identified based on these (and other) socio-demographic characteristics. Thirdly, as participants received a token reward for their participation in the focus groups, this may have encouraged individuals to attend simply for a reward. Fourthly, given the topic, those young adults interested in healthy lifestyles may have been more likely to respond to the recruitment notices than those uninterested. Fifthly, given that we have holistically explored three behaviours (food, alcohol and physical activity), we have not been able to cover in-detail all of the relevant literature which explores each behaviour individually. In terms of analysis, this holistic approach may have also prevented a deeper exploration of each behaviour; and also adds limitations to reporting of the data given such a large dataset. Lastly, as the data was collected a number of years ago, caution is urged from drawing firm conclusions. Future research should explore the interlinkages between these behaviours in a representative sample to verify these exploratory results.

Limitations aside, this exploratory research highlights the holistic relationship between food, alcohol and physical activity behaviours for young adults. In particular, the exchanges that young adults consider in relation to a specific behaviour proposition (a healthy lifestyle) have been highlighted. In doing so, this research suggests that this age range (19-24 years) is a key stage in young adult's lives, and this period of emerging adulthood is an opportunity to encourage young adults to adopt healthier lifestyle behaviours. In particular, and in order to encourage present-day behaviour change rather than future behaviour change, health promotional material may need to be alternatively framed to better accommodate the exchanges – the benefits and costs - that young adults associate with healthier lifestyles. Potentially, legislation may be needed to change resistant behaviours such as binge drinking and combat commercial marketing of unhealthy foods; together with counter-marketing to emphasise the benefits of healthy behaviours tailored to young adults. Future research would benefit from utilising a representative sample of young adults, perhaps focusing on whether certain socio-demographic characteristics are related to specific food, alcohol and physical activity behaviours and attitudes surrounding the behaviour proposition of healthier lifestyles.

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### Figure legends

Figure 1: Analytical framework: Behaviour proposition

