Special Session Summary  Diagnosing Identity: Exploring the Complex Relationship Between Consumer Identities, Motivation, and Health-Related Behaviors

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SPECIAL SESSION SUMMARY

Diagnosing Identity: Exploring the Complex Relationship between Consumer Identities, Motivation, and Health-Related Behaviors
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SESSION OVERVIEW

Consumer research has demonstrated the link between identities and consumer behavior, and we have long known that people use products for self-expressive reasons (e.g., Gardner and Levy 1959). However, less attention has focused on how people’s identities motivate identity consistent behavior. The papers in this session examined the motivational forces that underlie different kinds of identities and how these forces motivate the consumer towards identity consistent behavior or drive them away from identity inconsistent behavior. Further, all three papers focused on the relationship between identity and behavior in the health domain, an economically important and socially relevant domain that receives limited theoretical attention. The three papers in the session took different approaches to considering identity, the significance of the source of the identity, and how these identity “meanings” may influence consumer attitudes and practices related to their health and well-being.

Rika Houston examined the macro identity of “motherhood.” Motherhood is an identity that reflects an aspirational, role transitional, “desired self” that many women adopt in North American culture. Her presentation described the emotional, financial, and medical health of consumers facing the cultural dilemma of involuntary infertility during their quest to attain the desired social identity of “mother.” By integrating the analysis of historical and cultural text, secondary data, and ethnographic fieldwork, she presented a conceptual framework for understanding how the cultural-determined identity of motherhood affects consumers’ identity consistent behaviors in the infertility marketplace.

Michael Basil and Edward Maibach examined how people’s behaviors reflect an avoidance of a particular identity through an examination of consumer obesity. Being “obese” represents a “feared self” that is antithetical to the proliferation of popular culture driven idealized self-imagery. Their research created attitudinal and behavioral profiles of people who are obese in order to identify cognitive prototypes that underlie an avoidance-type of motivational force. Their nationally representative results suggest significant behavioral differences among those who are objectively vs. self-identified as overweight, and pose significant implications for interventions to curb the nation’s obesity epidemic.

Sonya Grier described her research with Amy Marks that investigated how multiple identities influence women’s smoking behavior. Their research utilized both qualitative and quantitative research to identify the key determinants of smoking behavior among women in South Africa, and the role of culture as a protective factor. Their results illustrated the process consumers use to manage the motivations generated by multiple, sometimes conflicting identities on behavior. The discussion leader for the session, Americus Reed II, made integrating comments and promoted discussion between the participants and the audience in order to allow a larger understanding of the topic to emerge.

Overall, the three presentations and the discussion that followed provided insight into how the motivations inherent in attaining, avoiding or managing identities influence health-related behaviors. The session’s methodological pluralism, incorporation of prior research, the social relevance of the topic, and the provocative Q&A session contributed to a more holistic understanding and provided a conceptual platform for those in attendance to truthfully address the complex relationship between health, identity and consumer behavior.

ABSTRACTS

“The Motherhood Mandate: Gender, Identity, and Consumption in the Infertility Marketplace”
H. Rika Houston, California State University, Los Angeles

This paper explores the emotional, financial, and medical health of consumers facing the dilemma of involuntary infertility. The significance of this dilemma cannot be understated since motherhood has been viewed as the primary vehicle through which women have formed their identities and found their “place” in contemporary North American culture since the beginning of the 19th century (Arendell 2000, Bassin 1994). Indeed, the intensity of this cultural mandate is so strong that the state of involuntary non-motherhood has now become medicalized through the birth and proliferation of a multi-billion dollar infertility industry since the 1970s.

After making the life-altering decision to become a parent in the first place, the inability to do so after repeated attempts seems to contribute to a slow downward spiral of emotions exacerbated by high price tags, low success rates, and a growing list of real and potential medical complications. From an emotional perspective, the ‘infertile’ are described as sharing the typically negative characteristic of ‘desperation.’ For example, ethnographic interviews of in-vitro fertilization consumers conducted by Franklin (1997) and ethnographic field work conducted by this author clearly reveal the overwhelming desperation and uncertainty experienced by female consumers of infertility products and services. Involuntarily infertile women, already burdened by self-doubts and desperation, often express further resentment at the public expectation of friends and family members who repeatedly ask them to explain the details of their personal dilemma or to justify their relentless quest to become a ‘biological’ mother when other alternatives such as adoption or non-motherhood exist (Franklin 1997, Kirkman 2001, Wischmann et. al 2001). With such a heavy emotional burden, it is easy to understand the psychological motivation for such consumers to pay large sums of money in the infertility marketplace.

From a financial perspective, accurate cost estimates for infertility procedures are difficult to obtain due to limited regulation and wide variations in cost associated with factors such as the age of the consumer and the complexity and duration of the required treatments. However, ‘standard’ in-vitro fertilization (IVF) treatments alone can average around $8,000 to $10,000 for the first cycle of treatment to a total of $50,000 to $150,000 for a series of cycles that result in a successful pregnancy and a live birth (American Society for Reproductive Medicine 2002, Kershner 1996, Moore 1996, Stephen 1999). Additional procedures, usually necessary when the infertile consumer is a woman over the age of 35, often add thousands of dollars to these average costs. Needless to say, the price tags are considerably high even though some infertility clinics offer ‘money-back’ guarantees if treatment does not result in a live birth (Schmittlein and Morrison 1999). A financial cost versus benefit analysis of the assisted reproductive procedure price tag
presents a perplexing question that can only be explained by the deeply embedded psychological motivation that potentially drives such consumers to conform to the cultural mandate of ‘motherhood’.

Even after the emotional and financial challenges are confronted, the growing list of potential medical complications associated with infertility products and services is formidable. First and foremost, pregnancies facilitated by the consumption of assisted reproductive technologies are more likely to result in multiple births and multiple births are at considerably greater risk for medical complications (Schieve et al. 1999, Seifer et al. 2001). The Centers for Disease Control and Prevention (2000) and The National Center for Health Statistics (1999) reported that from 1980 through 1997, the annual number of twin births rose 52% while the annual number of triplet or higher-order multiple births rose over 400%. Compared to singleton births, a twin is seven times more likely and a triplet is over 20 times more likely to die in the first month of life. Premature birth, which occurs in 50% of twin pregnancies and 90% of triplet pregnancies, is associated with an increased risk of respiratory distress syndrome (RDS), intra-cranial hemorrhage, cerebral palsy, blindness, deafness, low birth weight, and neonatal morbidity and mortality. Maternal complications of multiple gestations only complicate the matter. They include premature labor, placental abnormalities, maternal hemorrhage, pre-eclampsia, gestational diabetes, anemia, and other complications resulting from the cesarean birth that is standard practice with multiple gestation (American Society for Reproductive Medicine 2001). The most troubling unanswered question, however, is whether or not the ovulation drugs used by millions of infertile female consumers will increase their risk of developing ovarian cancer later in life (Hesselberth 2000, Kershner 1996). Although there still has not been any conclusive cancer research related to the hyper-stimulation of ovaries with ovulation drugs, the Food and Drug Administration now requires many fertility drugs to carry a warning that they may increase the risk of ovarian cancer. In summary, the multi-faceted combination of emotional, financial, and medical challenges involved with the consumption of products and services in the infertility marketplace bear witness to the strong impact that the culturally fostered identity of ‘mother’ has upon the health behaviors of women who find themselves caught in the quandary of this complex dynamic.

Through the use of secondary data, a comprehensive analysis of historical and cultural texts on the history of assisted reproductive technologies, and ongoing ethnographic field work, the author proposes a conceptual framework for understanding this timely gaze into the social and technological construction of consumer identity and their related health behaviors. Results point to existing public policy to address the needs and rights of consumers in the infertility marketplace, as well as possible avenues for future public policy.

“Obesity: Government Definitions Versus Self-Identity on Consumer Attitudes, Perceptions, and Behaviors”

Michael Basil, University of Lethbridge
Edward W. Maibach, Porter Novelli

The prevalence of obesity has increased dramatically in the United States recently (Flegal, Carroll, Kuczbarski & Johnson, 1998; Galuska, Serdula, Pumak, Siegel & Byers, 1996; Kuczbarski, Flegel, Campbell & Johnson, 1994; NHLBI, 1998). Being overweight increases the risk of hypertension, lipid disorders, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea, respiratory problems, and certain cancers (NHLBI, 1998). The total costs approaches $100 billion annually (Wolf & Colditz, 1998). From a marketing perspective, the most important questions to answer about obesity revolve around people’s current beliefs, attitudes, and behaviors. Do people perceive themselves to be overweight or obese? Do people see themselves to be at risk as a result of their weight? Do they feel self confident in their ability to do something about their weight? Only to the extent that people feel efficacious should we expect them to act. If people do not feel confident regarding things they can do to control their weight, the starting point should be an effort to build efficacy. This research explores these questions by examining the attitudes and behaviors of those who are objectively overweight with those who are not objectively overweight but self-identify that way.

The majority of the data for this study are from Porter Novelli’s Healthstyles survey, which is administered annually. For each of the focal years (1995, 1996 and 1996) the survey received a response rate of at least 70%, and sample sizes included approximately 3000 individuals. In addition, data from Porter Novelli’s 2002 Consumerstyles was also used. The mean reported weight was 172 pounds (188 for men, 160 for women, F[1,8602]=842, p<.001). The calculated body mass index (BMI) was 27.3 (27.3 for men, 27.2 for women, F[1,8602]=0.49, p>.10). This compares closely to NHANES-III and BRFSS data (Flegal et al., 1998; Kuczmarski et al., 1994, 1997; Galuska et al., 1996). Key analyses compared objective and subjective evaluations of obesity on a variety of psychological and behavioral differences.

First, people who are obese by government standards tend to perceive themselves as overweight. However, there are a considerable number of people who are overweight by government standards but do not describe themselves as being at least 20 pounds overweight. In addition, 12 percent of people who are not overweight estimated themselves to be at least 20 pounds overweight. With regard to attitudinal differences, the results show that objective obesity level shows a strong positive relationship with perceptions of health risk and weaker negative relationships with the importance of life satisfaction and perceptions of physical fitness as attractive. The results show that objective obesity level shows a weak negative relationship with confidence in maintaining a low-fat diet and with exercising regularly, but a strong negative relationship with confidence in staying thin or losing weight. With regard to questions of actual behaviors, the results show a weak negative relationship between the objective level of obesity and peoples’ fruit and vegetable consumption and moderate relationships with days per week of moderate and strenuous physical activity. This relationship gets stronger, however, using people’s self-identification of being overweight. In this case the behaviors are more strongly related to identification as overweight than the government categories.

Addressing again the issue of self-confidence, is the determinant of confidence a person’s objective obesity level, their subjective identification as overweight, or from people’s behavior? In this case the results show that the largest predictor of people’s confidence in being able to maintain a low-fat diet show their previous experience with low fat eating. The second largest predictor of confidence is a person’s age, such that older people are more confident in these abilities. The analysis of people’s confidence in being able to exercise regularly shows that experience with moderate exercise is the largest predictor of confidence. The second largest predictor of confidence is their current level of strenuous exercise. The analysis of people’s confidence in being able to stay thin or lose weight shows that current obesity level is the largest predictor of their current level of confidence. The second largest predictor of confidence is their current level of strenuous activity.
In sum, all of the analyses demonstrate that the largest predictor of self-confidence in being able to maintain a low fat diet, exercise, or lose weight is their current status on that behavior. These data appear to closely follow trends observed elsewhere. In general, almost 60% of the sample can be categorized as overweight. Although overweight people generally know they are overweight, suggesting that the message of what constitutes overweight has reached this population. With increasing obesity, people’s life satisfaction declines, they see physical activity as less important and less attractive, they have slightly less confidence in being able to maintain a low fat diet, slightly less confidence in being able to exercise regularly, but much less confidence in being able to lose weight or keep it off. And while objective obesity was related to feeling at physical risk as a result of their weight, the subjective evaluation of being overweight was more important. Obese people express an interest in low fat foods, but appear skeptical that it will evaluation of being overweight was more important. Obese people express an interest in low fat foods, but appear skeptical that it will result in a respondent sample of 1314, with 959 non-smokers and 355 smokers. Two stage logistical regression analysis indicates that both cultural and health conscious identities serve as significant predictors of behavior independently of other TRA/TPB variables and that they significantly improve the model’s ability to classify respondents as smokers versus non-smokers. The first model using TRA/TPB variables classified 86.7% of the respondents into smoking versus non-smoking [-2LL=768.428, X^2=643.140, 4 df, p<.000], with the odds ratios showing attitude to contribute the most to the model (1.517), followed by injunctive cultural norms (1.133) and descriptive norms about friends’ smoking (.353). Adding the cultural and health identity variables significantly improved the model’s ability to classify smoking behavior to 92.1% [-2LL=638.580, X^2=772.987, 6 df, p<.000, change in -2LL of 129.848, 2 df, p<.000], with the odds ratios showing attitude to still contribute the most to the model (1.596), followed by health identity (.802), cultural identity (.54) and then descriptive norms about friends’ smoking (.415). The addition of the identity measures rendered cultural norms insignificant, and since the identity and norms variables are correlated, further analyses of the interactions will investigate their joint effect on smoking, with particular interest in the relative effect of individual level identity (health) versus social level identity (cultural).
References


