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# Perceived Behavioral Control and Self-Efficacy of Overweight and Normal Weight Adults Regarding Exercise at a Health Club

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### ABSTRACT

**Purpose:** Only a small fraction of overweight people get enough exercise to improve health. Intimidating factors in the health club environment may cause the overweight person to have low perceived control and low self-efficacy for exercise. **Objectives:** The objectives of this study were to determine the perceived behavioral control and self-efficacy overweight (OW) and normal weight (NW) adults have toward health club exercise and what individual factors affect their perceived control and self-efficacy. **Method:** A 17-item survey measured perceived behavioral control, self-efficacy, and behavioral intent toward exercising at a health club 30 min, twice a week, for the next month, in overweight (OW, n=1159) and normal weight (NW, n=550) adults. ANOVA, t-tests, Mann-Whitney Rank Sum, and correlation coefficients were used for analysis. Significance was set at  $p < 0.05$ . **Results:** NW adults have higher overall self-efficacy, higher overall perceived control, and higher perceived control over their ability to exercise, having what is necessary to exercise and wanting to exercise more than do OW ( $p < 0.002$ ). Exercise intent is related to perceived control ( $r = 0.56$ ) and self-efficacy ( $r = 0.41$ ). OW people feel least efficacious about exercising with heavy work demands or stressful life changes. **Conclusions:** Exercise promotions and interventions in the health club environment should provide support and skills for overcoming these barriers.

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### INTRODUCTION

It is well recognized that regular physical activity and moderate to vigorous intensity exercise will lower the risks and symptoms associated with the co-morbidities of being overweight. Moreover, exercise is the only factor that is constantly associated with reduced weight maintenance for the previously overweight.<sup>1</sup> In addition to what the research indicates, overweight people themselves recognize the importance of exercise in weight control. For instance, 82% of those who used exercise to lose weight reported the reason they regained weight is because they stopped exercising.<sup>2</sup>

In spite of the acceptance of exercise as the antidote for being overweight, only a small fraction of the overweight population gets enough physical activity to reap any health benefits.<sup>3</sup> Only 31% of those trying to lose weight meet the National Institutes of Health guidelines for exercise and less than one in five trying to lose weight meet the Institute of Medicine exercise recommendations.<sup>4</sup> On the other hand, 97% of overweight individuals affirm that they would be willing to exercise 50 min/d, 5 to 6 days/week (d/wk) in order to lose weight.<sup>2</sup>

The conflict between what the overweight person perceives as correct (to exercise) and how the overweight person behaves (not exercise) is called ambivalence.<sup>5</sup> Health-related ambivalence makes it psychologically difficult to change health-related behaviors

or to resist the temptations of unhealthy choices.<sup>5</sup> Thus, the overweight person has a difficult time exercising, because of the dilemma of the ambivalence surrounding that behavior. In order to resolve this dilemma, it is necessary to examine the specific sources of ambivalence in the theoretical constructs of behavior.

Many researchers studied the correlates of physical activity within the paradigm of the Theory of Planned Behavior (TPB).<sup>6-9</sup> Their research shows that the TPB is an appropriate theoretical framework for understanding the determinants of physical activity in several populations. Most recently, the TPB has been shown to be an efficacious model to explain the correlates of physical activity in overweight adults.<sup>10</sup> The value in finding that the TPB explains the correlates of physical activity in overweight adults is that the constructs of the TPB model can now be used to design interventions to change behavior.

The TPB proposes that one's intent to perform a behavior and its actual performance are determined by three independent constructs: attitudes toward the behavior, subjective norms, and perceived behavioral control. Specific salient beliefs underlie each of these cognitive constructs: behavioral beliefs (underlying attitude), normative beliefs (underlying subjective norms), and control beliefs (underlying perceived behavioral control).<sup>11,12</sup> The constructs for an individual are appraised by weighing the strength of the respective belief by a valuation of that belief. Thus, in order to understand why a person maintains a certain construct (attitude, subjective norm, or perceived behavioral control) toward a specific behavior, it is necessary to assess the person's beliefs as well as his/her respective valuations of those beliefs.

Research has shown that the construct of perceived behavioral control greatly predicts exercise intention.<sup>7-10</sup> The recent meta-analysis reported that the correlation between perceived behavioral control and exercise intention was relatively high ( $r = 0.57$ ).<sup>8</sup> Furthermore, when one adds a construct of self-efficacy to the TPB model, an additional independent proportion of the variance in exercise intention can be explained.<sup>8</sup> Since perceived behavioral control and self-efficacy both represent a person's capacity regarding a certain behavior and the ease at which the person believes he/she can perform the behavior, understanding these two constructs can help us identify and design interventions to overcome barriers to exercise for overweight adults.

In an effort to help overweight people overcome some of the barriers to exercise, the Centers for Disease Control and Prevention have recommended, among other things, joining a YMCA or health club. Since over 60% of the population has access to a health club, wellness program, or fitness facility, the first objective of this study was to determine the perceived behavioral control, self-efficacy, and intent toward health club exercise in overweight and normal weight adults.<sup>13</sup> The second objective of this study was to differentiate individual elements of perceived behavioral control and self-efficacy in the overweight adult that relate to health club exercise so that barriers to health club exercise for the overweight can be removed in the future.

## **METHODS**

### **Design**

In order to gain insight into what affects an individual's decision to exercise at a health club, this study used a survey instrument based on Ajzen's Theory of Planned Behavior (TPB).<sup>14,15</sup> Briefly, the TPB says that human action is guided by 1) one's attitude toward the behavior in question, 2) the perceived social pressure (subjective norm) to perform the behavior, and 3) the ease or difficulty with which one can actually perform the behavior (perceived behavioral control). The combination of attitude, subjective norm and perceived behavioral control leads to the formation of an intention to perform or not to perform a given behavior. Generally, favorable attitudes and positive subjective norms, in combination with a high level of perceived behavioral control, lead to a greater likelihood of actually performing and maintaining the behavior.<sup>14,15</sup> The likelihood of performing and maintaining the behavior is augmented when a high self-efficacy is present.<sup>8</sup> Two of the most critical factors, then, in guiding the overweight person's intent to exercise in a health club are perceived behavioral control and self-efficacy.

The questionnaire used for this study was developed following a format suggested by Azjen and Fishbein, and Francis et al, applying the perceived behavioral control constructs of the TPB to exercising in health club setting.<sup>14,15</sup> Information elicited from an in-depth qualitative study conducted by Brooks regarding the perceptions and beliefs of American adults about health clubs and the health club environment provided the content for this study.<sup>17</sup> As recommended, relevant attributes were identified from the information compiled in the Brooks study and used to tailor the TPB measures of the questionnaire specifically in relation to perceived behavioral control about exercising in a health club setting.<sup>16</sup> Survey questions for self-efficacy were modified from those of Sallis et al.<sup>18</sup>

Health club, in the current study, was defined as any commercial exercise facility. Although health clubs may vary in their approach and programs, the main study objective was to differentiate between home exercise and exercise at a commercial facility. Thus, this study dealt with one portion of that dichotomy, exercise at a commercial exercise facility (health club). Questionnaire items relating to the perceived behavioral control constructs of the TBP as well as self-efficacy and behavioral

intention were measured. This study was approved by the Institutional Review Board (IRB), and classified as “Exempt” for informed consent, because no identifying information was collected.

### Participants

Questionnaire participants were men and women recruited anonymously via electronic distribution of an online survey. Participants were recruited through the assistance of Luth Research, LLC (San Diego, CA) – an online marketing research company. Luth Research follows the standards of the Council of American Survey Research Organization (CASRO), the American Marketing Association, and the ESOMAR International Marketing Codes and Guidelines for market survey research. Luth Research keeps an online research panel of over 2.5 million households, representing the demographics of the U.S. census. The questionnaire sample was randomly pulled from a filtered group of respondents, based on the study qualifications. Participants were sent a personally encrypted link to the study. Data integrity was maintained by a multilevel check system.<sup>19</sup>

There were no specific exclusion criteria for participation in the study, other than being a minor. Therefore, participants under the age of 18 were eliminated from the potential recruitment database. All participants read a study information sheet that described the study purpose and voluntary participation prior to beginning the questionnaire. Participants were also asked to indicate their age, race/ethnicity, income level, weight and height, and self perceived general health status (poor, fair, good, very good, excellent). Age was subsequently categorized into three groups; < 35 y, 35 to 60 y, and > 60 y. The International Health Racquet and Sportsclub Association has found a distinct market separation among these three age groups, with similar marketability within each individual age group.<sup>20</sup> Weight and height were used to calculate the participants' BMI, which was categorized into the following: underweight/normal (BMI < 25), overweight (BMI 25 to 30), and obese (BMI > 30). A participant's failure to answer a question or complete a field on the questionnaire resulted in an “empty” cell in the data spreadsheet. Empty cells were not included in the data analysis.

### Questionnaire Constructs

For the measure of perceived behavioral control, participants were presented with four questions that focused on their perceived behavioral control about exercising at a health club at least twice per week for 30 minutes, for the next month (Table 1). Each control statement was scored on a 5-point scale (1=very difficult or disagree a lot to 5=very easy or agree a lot). One's intent to exercise at a health club for 30 minutes at least twice a week for the next month was evaluated with the same unipolar, 5-point scale (1=disagree a lot to 5=agree a lot). Self-efficacy was measured by presenting the participants with 12 situational barriers to exercising at a health club at least twice per week for 30 minutes for the next month. Self-efficacy statements were scored on a reverse 5-point scale (5=Sure I could do it to 1=Sure I could not do it).

**Table 1. Itemized Perceived Behavioral Control, Self-efficacy, and Exercise Intent Statements**

<b>Perceived Behavioral Control Statement</b> (1=very difficult or disagree a lot to 5=very easy or agree a lot)
1) For me to exercise at a health club at least twice per week for 30 minutes for the next month would be...
2) I have control over my ability to exercise at a health club at least twice per week for 30 minutes for the next month.
3) I believe I have all the things I need to exercise at a health club at least twice per week for 30 minutes for the next month.
4) If I want to, I can exercise at a health club at least twice per week for 30 minutes for the next month.
<b>Self-efficacy Statement</b> (1=sure I could not do it to 5=sure I could do it)
5) Stick to your exercise program at the health club when your family is demanding
6) Get up early, even on weekends, to exercise at the club
7) Stick to your exercise program at the club when you have household chores to attend to
8) Get up earlier to exercise at the club
9) Stick to your exercise program at the club even when you have excessive demands at work
10) Stick to your exercise program at the club after a long, tiring day at work
11) Stick to your exercise program at the club when social obligations are very time-consuming
12) Exercise at the club even though you are feeling depressed
13) Read or study less in order to exercise more at the club
14) Set aside time for a physical activity program at the club, for 30 minutes per day at least twice per week
15) Continue to exercise with others at the club even though they're exercising at a different pace than you
16) Stick to your exercise program at the club when undergoing a stressful life change (e.g., divorce, death in the family, moving)
<b>Exercise Intent Statement</b> (1=disagree a lot to 5=agree a lot)
17) I intend to exercise at a health club at least twice per week for 30 minutes for the next month.

Numbers in parentheses represent the five-level Likert item responses for the respective questionnaire categories.

### Statistical Analyses

Data were analyzed using the SigmaStat software program, version 3.5 (SigmaStat Software Inc, Point Richmond, CA). Demographic data and group scores are reported as mean  $\pm$  Standard Error of the Mean (SEM). A preliminary analysis was performed to see if there were group differences between individuals classified as overweight (OW, BMI 25-30) and those classified as obese (BMI > 30). No significant differences were found between the OW and obese for perceived behavioral control, self-efficacy, exercise intent, and health club membership. Thus, the OW and obese subgroups were combined into one OW group and the entire sample population was dichotomized into two groups, OW and normal weight (NW). Comparisons between the OW and NW groups were performed with a student's t-test. However, in many situations, the group data were either not normally distributed or had unequal variances, so a Mann-Whitney Rank Sum test was used to compare the two groups. A 2-way ANOVA was used to compare group data for more than one group (i.e., sub-analyses) with the Holm-Sidak post-hoc test for multiple comparisons used if a significant group difference was found. The Pearson Product Moment Correlation was used to determine the strength of relationship between two variables when the data were normally distributed, whereas the Spearman Rank Order Correlation was used when residuals were not normally distributed with a constant variance.

Internal consistency and reliability of the questionnaire were measured using the Cronbach's alpha. Perceived behavioral control scale scores and self-efficacy scale scores were analyzed for the entire sample. Internal consistency for perceived behavioral control was 0.86 and 0.96 for self-efficacy. In addition, internal construct validity was evaluated by determining the relationship between individual item scores and total scores for both the perceived behavioral control scale and the self-efficacy scale. Correlation coefficients ranged from 0.56 to 0.90 for perceived behavioral control and from 0.68 to 0.86 for self-efficacy. Significance for all statistical analyses was set at the level  $P < 0.05$ .

### RESULTS

A total of 800 men and 909 women (N=1709) completed questionnaire (Table 2). Sixty-seven percent were OW and 33% were NW. Ninety percent were Caucasian and 10% non-Caucasian. Twenty-four percent of the sample was younger than 35 y, 48% between 35 and 60 y, and 28% over 60 y. Seventeen percent of the sample held a health club membership, while 83% did not and more of those under 35 y were members (31%) than over 35 y (13%,  $P < 0.001$ ). Less NW individuals held a health club membership than OW (7% vs. 10% respectively,  $P < 0.0001$ ).

**Table 2. Participant Demographics**

Demographic Variable		Overweight	Normal Weight
Gender	Men	583 (34)	217 (13)
	Women	576 (33)	333 (19)
	Total	1159 (67)	550 (32)
Age	< 35 y	214 (12)	206 (12)
	25-60 y	590 (34)	234 (14)
	> 60 y	355 (21)	110 (7)
Race	Caucasian	1059 (61)	484 (28)
	Non-Caucasian	100 (6)	66 (4)
Income	$\leq$ \$25,000	257 (15)	104 (6)
	\$25,001-50,000	408 (23)	181 (11)
	\$50,001-75,000	243 (14)	113 (7)
	75,001-100,000	132 (8)	72 (4)
	> 100,000	119 (7)	80 (5)
Current Club Member		178 (10)	113 (7)

Numbers represent the total sample number with the percentage of the entire sample in parenthesis.

The NW group had a higher perceived behavioral control for exercising at a health club than the OW group (Table 3). Moreover, the NW group scored higher ( $P < 0.001$ ) on each individual item of perceived behavioral control than the OW group. Men had a higher perceived behavioral control over exercise at a health club than did women. Those younger than 35 y had higher perceived behavioral control than those over 60 y. There was no significant difference in perceived behavioral control between Caucasians and non-Caucasians. Perceived behavioral control for the entire sample was positively associated ( $r = 0.56$ ) with exercise intent ( $P < 0.0001$ ). Perceived behavioral control correlated with self-efficacy ( $r = 0.55$ ,  $P < 0.0001$ ).

**Table 3. Group Comparisons for Perceived Behavioral Control and Self-efficacy**

Comparison Group	Perceived Behavioral Control Score	Self-efficacy Score
OW	3.40 ± 0.03 <sup>a</sup>	40.1 ± 0.3 <sup>a</sup>
NW	3.65 ± 0.04	41.5 ± 0.5
Caucasians	3.27 ± 0.03	40.4 ± 0.3 <sup>b</sup>
Non-Caucasians	3.56 ± 0.08	42.4 ± 0.8
Men	3.43 ± 0.04 <sup>c</sup>	40.1 ± 0.5
Women	3.18 ± 0.04	38.5 ± 0.4
< 35 y	3.35 ± 0.06 <sup>d</sup>	39.3 ± 0.5
35-60 y	3.31 ± 0.04	39.4 ± 0.4
> 60 y	3.23 ± 0.05	39.1 ± 0.6
≤ \$25,000	3.08 ± 0.06 <sup>e</sup>	38.3 ± 0.7
\$25,001-\$50,000	3.27 ± 0.04 <sup>e</sup>	39.9 ± 0.5
\$50,001-\$75,000	3.38 ± 0.06 <sup>e</sup>	39.3 ± 0.7
\$75,001-\$100,000	3.49 ± 0.08 <sup>e</sup>	39.3 ± 0.9
>\$100,000	3.57 ± 0.08 <sup>e</sup>	39.3 ± 0.9

Values are mean ± SEM.

<sup>a</sup>Significantly different from NW, P<0.001.

<sup>b</sup>Significantly different from Non-Caucasians, P<0.05.

<sup>c</sup>Significantly different from women, P<0.001.

<sup>d</sup>Significantly different from other age groups, P<0.001.

<sup>e</sup>Significantly different from all other income levels, P<0.001.

Self-efficacy for exercise at a health club was significantly higher for the NW (41.5 ± 0.5) than the OW (40.1 ± 0.3) group. No differences in self-efficacy scores were found among ages, genders, and income levels. However, non-Caucasians had higher self-efficacy for exercise (42.4 ± 0.8) than Caucasians (40.4 ± 0.3). Self-efficacy was positively related ( $r = 0.41$ ,  $P < 0.0001$ ) to exercise intent.

Subgroup analyses within the OW group itself revealed the same similarities and differences in self-efficacy as were found when the sample was analyzed as a whole (Table 4). With regard to perceived behavioral control, OW men had a higher perceived behavioral control than OW women. NW non-Caucasians had higher perceived behavioral control than OW Caucasians, and those OW under 35 y more perceived behavioral control than those 35 y and older. Those earning less than \$50,000 had less perceived behavioral control over exercise than those earning above \$75,000 (Table 4).

**Table 4. Group Comparisons for Perceived Behavioral Control and Self-efficacy of OW Participants**

Comparison Group	Perceived Behavioral Control Score	Self-efficacy Score
Caucasians	3.18 ± 0.03 <sup>a</sup>	38.7 ± 0.4 <sup>a</sup>
Non-Caucasians	3.53 ± 0.11	42.5 ± 1.3
Men	3.37 ± 0.04 <sup>b</sup>	39.8 ± 0.6
Women	3.03 ± 0.05	38.2 ± 0.6
< 35 y	3.29 ± 0.08 <sup>c</sup>	39.5 ± 0.8
35-60 y	3.20 ± 0.05	38.9 ± 0.5
> 60 y	3.20 ± 0.06	38.9 ± 0.7
≤ \$25,000	3.00 ± 0.08 <sup>e</sup>	36.8 ± 0.9
\$25,001-\$50,000	3.20 ± 0.06 <sup>e</sup>	39.9 ± 0.7
\$50,001-\$75,000	3.30 ± 0.08	39.3 ± 0.8
\$75,001-\$100,000	3.51 ± 0.11	39.6 ± 1.2
>\$100,000	3.51 ± 0.10	39.5 ± 1.1

Values are mean ± SEM.

<sup>a</sup>Significantly different from Non-Caucasians, P<0.01.

<sup>b</sup>Significantly different from women, P<0.002.

<sup>c</sup>Significantly different from other age groups, P<0.005.

<sup>e</sup>Significantly different from >\$75,000 income levels, P<0.001.

## DISCUSSION

Many researchers have studied the correlates of physical activity within the paradigm of the TPB.<sup>6-9</sup> Most recently, the theory has been shown to be an efficacious model to explain the correlates of physical activity in OW adults.<sup>10</sup> The TPB proposes that one's intent to perform a behavior and its actual performance are determined by three independent constructs: attitudes toward the behavior, subjective norms, and perceived behavioral control. Recently, self-efficacy has been shown to be an important additional construct to the model.<sup>8</sup> Since perceived behavioral control and self-efficacy both represent a person's capacity regarding a certain behavior and the ease at which the person believes he/she can perform the behavior, the two constructs focused upon in this study were perceived behavioral control and self-efficacy. The intent of this study was to identify specific areas where OW adults perceive a high degree of control and feel most efficacious about health club exercise.

Some major findings in this study are that perceived behavioral control and self-efficacy toward health club exercise were lower in OW than NW adults. In addition, men had higher perceived behavioral control over health club exercise than women. When the OW group was analyzed separately, OW men showed greater perceived behavioral control for health club exercise than OW women, and OW non-Caucasians had more perceived behavioral control and self-efficacy than OW Caucasians.

Since the OW person felt less behavioral control and self-efficacy about health club exercise than the NW person, the place to begin to discover where exercise barriers exist for the OW person is in analyzing individual self-efficacy and behavioral control statements. An ANOVA for individual rank scores for the perceived behavioral control statements revealed that the OW person felt he/she had the most control over his/her innate ability to exercise at a health club ( $3.82 \pm 0.04$ ), but at the same time, had the least control over actually doing it ( $2.67 \pm 0.04$ ,  $P < 0.001$ ). A similar ANOVA analysis for individual ranking of scores for each of the self-efficacy statements revealed that the OW person felt most efficacious about 1) exercising with others who are exercising at a different pace, 2) setting aside time to exercise, 3) exercising even when feeling depressed, and 4) exercising even when having household chores to do. On the other hand, the OW person felt least efficacious about 1) exercising after a long day at work, 2) exercising when undergoing a stressful life change, 3) exercising when there are excessive demands at work, and 4) getting up earlier to exercise. Altogether, it appears that the overweight person perceives he/she has the innate ability to exercise at a health club, and is capable of doing so within the realm of his/her personal life; but finds it difficult to do so because of work-related factors that seem to control life's daily schedule.

OW Men, more than OW women, felt that if they wanted to, they were capable and had what they needed to exercise at a health club ( $P < 0.008$ ); but were similar to women in feeling they did not have control over being able to go and exercise ( $P = 0.203$ ). OW Men were also similar to OW women in overall self-efficacy about health club exercise ( $P = 0.197$ ), but more efficacious about getting up earlier, even on weekends, to exercise ( $P < 0.008$ ). This means that OW women have significantly more perceived barriers to exercise than men, and that exercise interventions targeting OW women have to remove barriers related to time and innate abilities as well as those barriers that are common to men.

OW men and women under the age of 35 felt that they were capable and had all they needed to exercise at a health club more than those over 35 y ( $P < 0.003$ ). Those OW men and women who were under 35 y also felt more efficacious about exercising when depressed than those over 35 y ( $P < 0.03$ ). This implies that exercise interventions for OW adults who are middle age or older need to build self-efficacy about exercise capabilities, particularly when one is feeling depressed.

OW non-Caucasians showed more perceived behavioral control over their capability to exercise, particularly when they wanted to, than OW Caucasians ( $P < 0.01$ ). Moreover, OW non-Caucasians reported higher self-efficacy than Caucasians for all aspects of health club exercise, except for when there were excessive work demands or stressful life changes placed upon them ( $P < 0.004$ ). These findings seem paradoxical in that the prevalence of obesity is greater in non-Caucasians than Caucasians, and a lower percentage of non-Caucasians are physically active than Caucasians.<sup>21</sup> However, this may not be that surprising in that the non-Caucasians showed a higher ( $P < 0.001$ ) intent to exercise at a health club than Caucasians.

The data from this study indicate that NW adults have higher perceived behavioral control and self-efficacy about health club exercise than OW adults, and that men have a higher perceived behavioral control over health club exercise than women. Possibly more important than the general findings on perceived behavioral control and self-efficacy is the fact that the OW adult felt least efficacious about exercising when they face heavy work demands and stressful life changes. Exercise promotions and exercise interventions for obesity in the health club environment should provide support and skills for overcoming these behavioral control and self-efficacy barriers. In other words, health clubs can have more of an impact in the war against obesity if they cater to the OW adult by helping him/her gain more control over the exercise environment and by helping him/her design strategies for exercising when under stress.

## CONCLUSIONS

Just a few years ago, the TPB was shown to be an efficacious model to explain the correlates of physical activity in overweight adults.<sup>10</sup> This current study, along with our two most recent studies, confirm the usefulness of the TPB for explaining health club exercise behaviors of OW adults.<sup>22,23</sup> The value in finding that the TPB explains the correlates of physical activity in overweight adults is that the constructs of the TPB model can now be used to design interventions to change behavior. Most important is that the findings from our previous two studies, along with those of this study, can identify what specific attitudes, subjective norms, perceived behavioral control issues, and self-efficacy issues regulate the OW person's participation in health club exercise. Knowledge of how these behavioral constructs affect the OW person's ability to become more physically active is a valuable tool the health professional can use to implement behavior change in their OW clientele. Table 5 presents some intervention strategies relevant to the constructs of the TPB that the health professional can use to help OW adults overcome barriers to health club exercise.

**Table 5. Application of the TPB Constructs to Promote Health Club Exercise in OW Adults**

TPB Construct	Suggested Intervention Strategy
Attitudes <ul style="list-style-type: none"> <li>OW people are embarrassed about exercising, and are intimidated by the health club environment.<sup>22</sup></li> <li>OW people feel exercise will increase their health and well-being as well as their self image.<sup>22</sup></li> </ul>	Evaluate each individual's beliefs about health club exercise. Minimize the intimidating aspects about the immediate exercise environment. Promote the benefits of exercise to health and well-being. Reinforce the positive beliefs about health club exercise through repetition. Minimize and dismantle the negative beliefs about health club exercise.
Subjective Norms (Normative Belief and Motivation to Comply) <ul style="list-style-type: none"> <li>OW people perceive more social pressure to exercise and are most motivated to comply with that pressure when it comes from their doctor, spouse or partner, and important people in their lives.<sup>23</sup></li> </ul>	Encourage cooperative agreements for health club exercise among the OW person and influential people in their life. The agreement should attempt to meet the expectations of the OW person in accordance with the subjective norm coming from these influential people.
Perceived Behavioral Control <ul style="list-style-type: none"> <li>OW people feel most control over their innate ability to exercise, but least control over actually doing it.</li> </ul>	Capitalize on the OW person's perception of their ability to exercise with praise, encouragement, and exercise programming that focus on their innate exercise interests and abilities; while designing methods to overcome specific barriers to exercise.
Self-efficacy <ul style="list-style-type: none"> <li>OW people are most efficacious about finding time to exercise, exercising with people dissimilar to themselves, exercising when depressed, or when having home chores to do.</li> <li>OW people feel least efficacious about exercising after a long day of work, with excessive work demands, when under a stressful life change; and getting up early to exercise.</li> </ul>	Capitalize on the OW person's ability to find time to exercise in different social realms, but do not encourage them to find that time early in the morning or after a hard day's work. Design ways the OW person can modify their exercise program when they have excessive work demands or under a stressful life change.

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