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*Children's Television Workshop*

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## **SOME LESSONS FROM THE *FEELING GOOD* TELEVISION SERIES**

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There has been a lot of discussion recently, in the press and elsewhere, about the need for more preventive health action on the part of the public. This concern was the basis for the *Feeling Good* project. The original proposal was for 26 one-hour programs to be broadcast weekly on Public Broadcasting Systems (PBS). When we were about 6 programs into the series, however, the decision was made to stop after the first 11 one-hour shows, take a two-month break to retool and return with 13 half-hour shows.

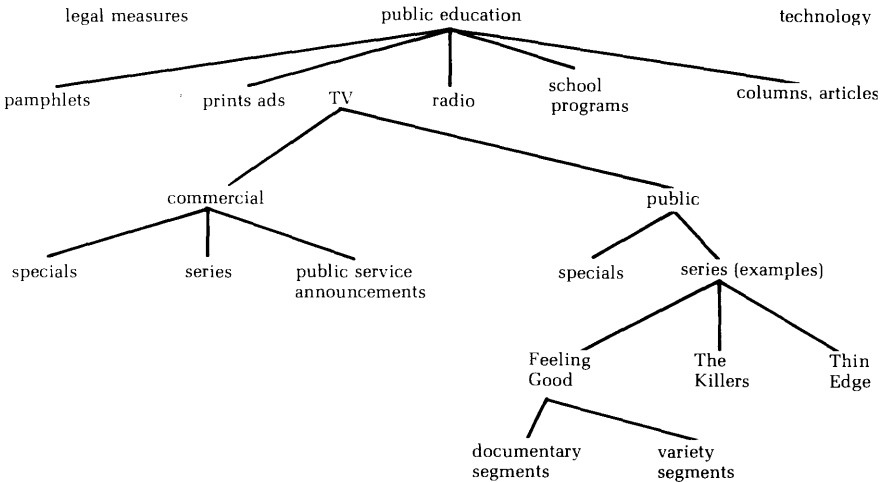
Leon Robertson talked about some of the problems with using education as a means of trying to influence people to do things we all know we are supposed to do. Most of the time, as he noted, results are rather discouraging. People do not pay much attention, or if they do pay attention and learn, they still do not do what they say they know they should do.

Education is one means of getting people to do things. Technology and legislation are two other means of making things happen. Our program did not deal with either the passage of new legislation or the enforcement of existing legislation in such areas as the use of fluoridation or seat belts. We were not involved with technology. Technological solutions to some problems are obviously going to lessen the necessity for public education. Even with technological advances, however, there will still be need for people to know about health problems and what they can do about them.

To provide a context for discussing our series, let us focus first on health education in general (Figure I). Pamphlets, radio, television, films, newspaper columns, and a variety of other things are used in health education. Television alone can be split into commercial and non-commercial.

**FIGURE I**

**Some Mechanisms for Modifying Health Behavior**



On commercial TV there are specials on such topics as alcoholism, heart disease, costs of care, and polemic pieces like, "Don't Get Sick in America," or "What Price Health?". There are regular non-network series such as *Medix*, a syndicated half-hour program produced by an independent producer and purchased by individual stations for showing on a regular basis. There are public service announcements, most of which are shown during the day or in the wee hours on an unpaid and unscheduled basis; the originating organization cannot control when they are shown. In some cities, two-minute special health inserts are used on news programs. There are some rather special kinds of things that do not really fit under the normal series category, such as occasional treatment of a health topic in a regular series, for example, *Maude*, *All in the Family*, *Good Times*, or daytime serials.

On non-commercial TV there are specials, one-time programs like *Drink, Drank, Drunk* and *VD Blues*; and there have been limited series such as *The Killers*, *The Thin Edge*, and *Inside Out*. *Feeling Good* was a somewhat different case, and I will talk a little about some of the things that were good, bad, and indifferent about it as we go along.

We were trying to reach several kinds of people with this series, as indicated by these hypothetical examples:

Martha Thompson is 53 years old, is married, has 3 kids aged 14-24, and lives in Muncie, Indiana. Her husband is a high school teacher who has a heart condition but has not seen a doctor in a year. Mrs. T. is overweight and has tried eight diets but has never lost

weight. They can not get a good signal on Channel 49 and thus rarely see a PBS program.

George Carruthers is 26, married, and has two kids aged 3 and 5. George lives in Atlanta, is black, has a high school education and works for an insurance company. He does not know if his kids have been immunized or whether they have had their vision and hearing checked. The family has no doctor, and uses an emergency room when necessary. The Carruthers watch a lot of TV but see only an occasional special on PBS.

Linda Harris is 35 and is the wife of a dentist in Larchmont, New York, with two kids aged 3 and 6. She is very interested in and knowledgeable about health matters, and regularly watches WNET, the educational channel in New York. Linda has a college education and thinks most entertainment programs on commercial TV are junk. She smokes a pack of cigarettes a day, and she worries about cancer.

Joseph Hernandez is 23, married, has one child aged 3, lives in Los Angeles, and does construction work. His wife works in a department store and has just become pregnant again but does not expect to see a doctor until she is in her sixth month. The Hernandez family has no regular doctor and no health insurance.

We want to reach all of these people, at the same time if possible, and you're going to say, "That must be pretty hard to do." You're right.

Let's consider briefly some kinds of programming on television (Figure II). There are entertainment programs, commercials, news and public affairs programming. There is also instructional television. There are others but let us end the list with *Feeling Good*. Now what requirements are these programs supposed to meet? Well, for one thing, they are supposed to attract an audience and hold it and, in some cases, they are supposed to attract a new audience not normally seeing this particular type of thing. Sometimes they are supposed to be fair and objective. They are supposed to convey information effectively and are judged on how well they do that, and in some cases they are supposed to motivate behavior.

Entertainment programs as a rule have one job, and that is to attract an audience, deliver an audience for commercials. Commercials themselves do not have to attract an audience and as a rule, they are not judged by how fair or objective they are. Some commercials are supposed to convey information, but that is not really a requirement. The real question is "Do they move the product off the shelf?" and that is the measure on which they are judged. News and public affairs programs are next. While some people would say that they are supposed to attract an audience, and it is obviously better if they do as far as the network or the station is concerned, it is not really a prime consideration in assessing how well they work. Must

**FIGURE II**

**Kinds of Programs**

Requirements	entertainment	ITV	Feeling Good	news, public affairs	commercials
attract & hold audience	X				X
be accurate & fair		X	X		X
convey information effectively			X	?	X
persuade viewer to take action				X	X

they be fair and objective? Yes. Must they convey information? Not necessarily. Motivate behavior? No. With instructional television, do you have to attract an audience? No; the audience is there by choice. Do you have to be fair and objective? Well, presumably. Do you convey information? Yes; that is how it is judged. Do you motivate behavior? No. Now we come to the *Feeling Good* series which was supposed to attract an audience, be fair and objective, convey information, and motivate behavior.

In some cases we hit some rather severe interdecisional conflicts. For example, we found that use of a laugh track with applause and laughter would improve the appeal of some segments but it would diminish the effectiveness of the segments in conveying information. Another interdecisional conflict involved the choice of focusing on one topic or several per program. We wanted to get around the problem of self-selection of audiences; if you do a program on hypertension for example, you are likely to attract an audience of people already interested in and knowledgeable about hypertension or health in general. We wanted to attract a wider audience, so we started out with programs dealing with three or four topics each. We also had a conflict in considering the regular PBS audience, which tends to be somewhat above average in income and education, and the target audience defined in terms of health needs. These people knew less about health, were likely to be less interested in a health

program, and were less likely to make use of the health care delivery system than those normally represented in the PBS audience. Some said it was foolhardy to try to attract this variety of audiences but we felt it was a worthwhile objective, particularly since the series was regarded as an experiment.

We knew that a good many previous programs, such as most documentaries on health topics, had been designed only to convey information and were intended primarily for an audience interested in health. We chose to focus on low-income families and young parents. We did this despite the fact that one normally can't expect a large proportion of these people to be in the public television audience. We also knew that most studies of mass communications indicate that they are far more likely to reinforce than to change attitudes, beliefs, or behavior. We undertook this program as an experiment, in part, to see whether this rather consistent finding could be modified.

I will review briefly some of the things we tried to do and mention some of the gaps between what we had intended to do and what actually happened.

*Behavioral Objectives.* At the beginning we tried to be quite explicit, with behavioral outcomes specified for production staff and writers. We prepared a writer's notebook with a description of each health problem chosen for treatment, its scope, and kinds of people affected. We developed explicit behavioral goals, and information to convey in support of these goals.

This was an information strategy where we did not just provide facts—we asked what the consequences of stating those facts were. I will give you an example. We know that the rate of hypertension among blacks is twice as high as among whites. That is a fact; one can state it. What are the consequences of stating it? Well, as far as blacks are concerned, the positive side is that they may see themselves as more susceptible than before and therefore be more likely to get a blood pressure check, which is what we wanted. On the other hand, some may feel put upon and consider it a race-related thing and thus reject the information. What about whites? If we say the rate is higher among blacks, do we somehow lead whites to feel it is not their problem and thus decrease the number going for blood pressure checks? If you multiply that question by 10 within a given topic area and multiply the number of topics by 20, you have some idea of the scale of difficulty in dealing with stated objectives.

In selecting both the topics and the goals, we considered the importance of the problem, whether there was some efficacious action that could be taken by the viewer, whether it was feasible for the person to take the action, whether related campaigns were being conducted by voluntary and public health agencies, and how measurable outcomes might be.

*Data on Audiences.* Another critical thing we tried to do was to get adequate and comprehensive information on audiences. These data were needed to cut down the likelihood of saying something inappropriate and to give us some ideas about what kinds of approaches to use. For example, if you want mothers of preschool children to take their kids in for immunization or to complete immunization series once they are started, you need to know how many and what kinds of people have not had their kids immunized. We know that about a third of the preschool kids in this country are not fully immunized. We know some of the demographic correlates, and that under-immunization is as high as 50 percent in some inner-city areas. However, we could not find information on how many of those people without complete immunization for their kids believed that childhood diseases were not serious, who believed that there were troublesome side effects for immunization, or who did not know where to get their child immunized, or were afraid it would cost too much. Unless you have information of this kind, it is very hard to develop communication that will be effective.

*Undermining Barriers to Action.* Throughout, we tried to overcome such things as fear and apathy. For example, in the segment about breast cancer, we emphasized that most breast lumps are benign, that the cure rate after early detection is high, and that one can resume normal activities after a mastectomy. A segment on mental health attempted to counteract the beliefs that seeking psychiatric treatment is socially disapproved and that such treatment is costly and ineffective. We avoided fear appeals, instead emphasizing the benefits of taking some recommended action. We knew that, in trying to use motivational goals, some people needed to be informed in the first place, some people needed only to be reminded, and some needed to be persuaded. We have known for a long time that just giving information may not do very much good. We know that smokers are knowledgeable about the health damage caused by smoking, and overweight people know about the dangers of obesity, and so on, so it is not simply a case of people being uninformed—something else keeps them from taking appropriate actions to reduce their health risks.

*Multiple Appeals.* Whenever possible, we tried to make a point more than one way and used more than one appeal, including non-health related appeals. We used social approval, parental role responsibility, altruism, and others rather than saying, “Doing this will make you healthier.”

*Use of Entertainment.* Entertainment was used in an attempt to attract an audience of people who would not normally watch a health program—or read a health pamphlet, or call up a doctor and ask a question, or read a medical column in a newspaper. We used guest stars and comedy and music and drama in the hope that some

people would come for the entertainment and learn something useful while watching.

To illustrate the point, I will list the performers who appeared on *Feeling Good*. Some of these you will recognize and some you may not because they were chosen for appeal to different kinds of target audiences. The names: Pearl Bailey, Bill Cosby, John Davidson, Johnny Mathis, Shari Lewis, Charlie Rich, Johnny Cash, Arte Johnson, Charlie Callas, LaBelle, Tito Puente, Helen Reddy, B.B. King, Anne Murray, Howard Cosell, Bob and Ray, Joe Williams, Tammy Grimes, Ken Berry, Martin Mull, Charlie Pride, Stiller and Meara, Mel Tillis, Sally Kellerman, Trini Lopez, Bill Withers, Vivian Vance, Linda Hopkins, Dick Cavett, Larry Gatlin, Betty Buckley, Melissa Manchester, Estelle Parsons, and Stephanie Mills.

There was a considerable gap between what we wanted to do and what actually happened. The writers and producers found it very difficult. People who had been quite competent at doing entertainment programs or news and public affairs programs or commercials had never before confronted the problems of doing them all at once and in one program, and on PBS, and about health.

Shows like *Marcus Welby* and *Medical Center* deal with life and death drama. One of our advisors calls this type of program the "dramatic traumatic." By contrast, we were dealing with prevention rather than treatment or cure. How do you show a bad thing not happening? How can you portray somebody not having a heart attack? If we were doing a March of Dimes campaign, our poster kid would be skipping through the meadow instead of appearing in a wheel chair or on crutches. It's very hard to dramatize prevention and that is one reason, perhaps, why nobody had done it effectively.

*Recruiting Influence Agents.* In many cases we sought to motivate viewers to encourage a friend or family member to do something. For instance, "Take this self-quiz on heart attack risk for somebody you know"—like a wife taking it for a husband or vice versa. One of the payoffs of the series, according to our evaluation, was this exact thing. We did have people saying "Yes, I tried to get somebody to get a Pap test," "I tried to get somebody to get a blood pressure check," or "I did get my husband to the dentist."

*Concern about Side Effects.* An ancient medical motto says "The first thing is to do no harm." Normally, health educators have not had to worry about this, but there is enough evidence from recent studies to suggest that negative outcomes are possible. For example, some cancer education programs may have led people to delay the presentation of symptoms. Some drug education programs have encouraged experimentation with drugs. We were quite concerned about having such boomerang effects rather than the ones we intended to have, and special care was taken in developing program segments to avoid this.



*Referral Spots.* Each program included one or more “referral spots.” We had a national information source on the program but we encouraged the 250 PBS stations around the country to contact local health agencies and we told them when a referral would be going on the program. Local stations could override the national agency with their own local slides. A narrator on the national programs would be saying, for example, “Here’s where you can get more information about a stress test,” and up goes the sign that says call such-and-such number in Lincoln, Nebraska. We localized in this manner whenever we could.

*Testing Programs.* We have formative evaluation data on about 7,000 people tested on various pieces of television material. This includes material from several programs produced by others, an hour of sample material from CTW, our pilot show, seven of our one-hour programs, and all of our half-hour programs. These studies were done in 13 cities around the country and used a variety of methods: questionnaires, personal interviews, a program analyzer, and group interviews. In general, these methods tended to give us very similar findings.

Let me review some of the results of this research which falls under the heading of “Some Lessons from the *Feeling Good Series*.”

- Differential interest in topics seemed to override differences in themes or approaches to these topics. For example, a “heavy” topic such as cancer elicited more interest than other topics regardless of whether the appeal was to altruism or self-interest and whether the theme was prevention or treatment.

- Television segments using fear appeals were liked much less than those with attractive content such as a demonstration of correct behavior.

- Segments with a strong emotional or fear appeal tended to be understood less well than those with a straight informational style.

- Appeal and comprehension were directly related. In general, the more a segment was liked, the greater were the chances that it would be remembered correctly. Both appeal and comprehension tended to be related to the perceived usefulness of the information conveyed.

- Self-tests and other formats which directly involved the viewer rated high on both appeal and ability to convey information effectively.

- Terms which denigrate persons with certain kinds of health problems such as “fatso” or “drunk” were responded to negatively.

- Viewers sometimes drew incorrect inferences from dramas or comedy sketches. Such segments frequently held interest and scored high on appeal, but some audiences had difficulty distinguishing factual material from statements made for comedic or dramatic purposes.

- Believable dramatic situations were found to convey information effectively to diverse audiences, including those whose ethnic or other characteristics differed from those of the performers. That surprised me at first, but the more I thought about drama going back 4,000 years, the more I thought, “Of course.”

- In the context of a program with low information density, documentary segments and straightforward presentations of facts were usually far more effective than one might expect from their performance in isolation. In our early programs, these segments tended to be among the best liked and the most learned from. In a way, they may have been a relief for people who were seeking information and who found entertainment pieces too low in information content.

- Songs proved to be a high-risk format for conveying health information and inducing positive effects toward a recommended behavior. Some were regarded very favorably, while others were seen as inappropriate or foolish in the context of a health program. We had 36 original songs written for the hour long programs and half a dozen for the half hour programs. A lot of very good talent was involved. Some of the songs were exhortative, some were packed with information and these were the ones that tended to have low appeal. Those which alluded indirectly to a health problem or a health behavior, and picked up their meaning from the program context, were seen as very effective.

- Parody was clearly a poor vehicle for conveying health messages. The facts were often misinterpreted, especially when viewers were unfamiliar with the basis for the parody.

We had something over a million viewers per week through the course of the series. The average audience rating was 1.4 for the one-hour programs, 1.2 for the half-hour programs, and 1.4 again for the summer rerun of the half-hour programs. These figures are percentages of the 68,500,000 television households in the U.S. So overall, there were about 40 million viewer exposures if you figure the average audience cumulatively; 60 million if you figure total audience which is based on people watching six minutes or more of a program. (Some people always come in late and some leave early so the total audience is typically larger than the average audience.)

The results of our assessment of series impact on viewers can be summarized by topic in very brief fashion as follows: breast cancer—information and behavior change; nutrition—information and behavior change; adult vision—information and behavior change; children’s vision—suggestive change on information and attitudes, and no change on behavior; immunization—no changes; dental care—no changes; doctor/patient communication—no changes; alcoholism—information and behavior change; uterine cancer—no information change but a behavior change; heart disease—informa-

tion and behavior change; accident prevention and control—no change in information but some behavior change; hearing—information but no behavior change; stress—information change but no behavior change; exercise—no changes. (This summary is necessarily very general; details will be provided in several forthcoming evaluation reports on the series.)

A lot of things influenced these results, as you might guess. The amount of treatment given, the kind of production formats used, the intervals through the series at which topics were treated, the number of evaluation questions asked, the ratio of information questions to behavior questions, and so on, all affected these outcomes.

Some general conclusions based on experience with this series:

- Getting information on target audiences' beliefs and behavior as a basis for programming decisions is difficult but worth the effort.

- Stating program objectives explicitly poses a number of problems, but is useful for production and necessary for evaluation.

- Staff continuity is critical. Considerable time is required for people to learn from their experiences and to apply what they have learned.

- Staff commitment to the goals of the educational enterprise is vital.

- Mixing information, entertainment, and motivation is very hard.

- One hour a week is probably too much for a program of this type no matter how well it is produced. Picture a one-hour health program on a commercial network and try to decide how long it would last. If it dealt with prevention rather than dramatic things, and, if it tried to be motivational, my guess is a maximum of three weeks.

- The use of non-health appeals to stimulate action seems effective in many cases.

- People can be recruited as "influence agents" to try and encourage somebody else to take a given health action.

There is no formula for success. We are still looking for guidelines through additional analysis, but clearly no one can say "If you just do these things you're going to have a dandy, appealing, educationally effective, motivationally effective piece of television material."

Finally, it is possible to have a demonstrable impact on health knowledge and behavior with a TV series—even on public television, and even stressing prevention.