The Tanning Battle Continues: Indoor Tanning in Young Adulthood

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Many people have heard of indoor tanning and/or have tried indoor tanning at some point in their life. The Centers for Disease Control and Prevention define indoor tanning as “the use of a tanning bed, booth, or sunlamp to get a tan” (2015). Most indoor tanning facilities include lamps, beds, and booths that emit both UV-A and UV-B rays, which are rays that are simulated from the sun and penetrates different layers of the skin (FDA, 2010). How one person is to get a tan is based on the body’s injury response to the UV exposure (CDC, 2015). Indoor tanning is nearly a $5 billion per year industry in the United States (Heckman et al., 2015). What is UV exposure worth to you?

Indoor tanning holds many potential dangers which leads to damage to the skin and skin cancer. With every entrance to an indoor tanning facility and exposing yourself to artificial rays of UV exposure, the risk of skin cancer is increased nearly every time (CDC, 2015). The most common skin cancer that is at the highest risk is melanoma (CDC, 2015). Indoor tanning also causes the skin to premature age, resulting in wrinkles and age spots; it also changes the texture and feel of your skin; and increases your chances of a debilitating eye problems if eye protection is not used (CDC, 2015). The FDA recommends limiting exposure to natural UV exposure from the sun and completely avoiding artificial exposure from tanning beds because of the multiple risks and dangers that tanning beds pose (2010). Currently the FDA regulates the radiation-emitting products (i.e. sunlamps, etc.), and the manufacturers must comply with such regulations and standards (2010).

Indoor tanning effects anyone and everyone at all ages and races in life. Based off the 2010 National Health Interview Survey, most indoor tanners are young women that are non-Hispanic white (CDC, 2015). With many of these tanners being women and the risk of skin cancer is increased, in 2014 a study estimated that more than 400,000 cases of skin cancer may
be related to indoor tanning (CDC, 2015). Many studies that are currently being done on indoor tanning is solidifying the fact that indoor tanning leads to melanoma. Think about the women that you come in contact with in your life and how many of them are tanning? In the same study done in 2010, 31% of indoor tanners were aged 18-21 and 30% of indoor tanners were aged 22-25 (CDC, 2015). This shows that 61% of indoor tanners is the target population for this health behavior.

For the purpose of this health promotion program, the identified target population is men and women between ages 18 and 25. Even though many statistics have proven that women are typically determined as the main indoor tanners, men are also effected and indoor tan as well, and should not be forgotten. In a study done to understand the history of indoor tanning of young people, young men began indoor tanning around the age 21 (Lostritto et al., 2012). In the same article, young women began indoor tanning around the age of 17 (Lostritto et al., 2012). With these statistics, it paints a picture of at least three-quarters of females and over one-third of males will have tanned indoors at least once in their life before the age 40 (Lostritto et al., 2012).

For the purpose of this health promotion program, the protection motivation theory (PMT) is a model is based on the concept that perceived threat is analyzed on a costs and rewards system for the adaptive and maladaptive behaviors (DiClemente et al., 2012). This theory falls well with indoor tanning because this health behavior could be viewed as having costs and rewards to some people. With this theory, it is broken up into several separate components within the components; however, the best way to sum up the layout of this theory is in the following sequence: evaluating the chances of harm to themselves, the severity to outcome, the efficacy of response, and the self-efficacy of the individual (DiClemente et al., 2012). Related to indoor tanning, evaluating the chances of harm to themselves would include
the probabilities of skin cancer if an individual continues to indoor tan. The severity to the outcome of indoor tanning would be that individuals would be diagnosed with melanoma and have possible eye damage. The efficacy of response would be the effect the cessation of indoor tanning would be on cancer prevention. The self-efficacy of the individual would be the individual’s ability to not tan in an indoor tanning bed.

With a better understanding and added knowledge of PMT model, comparing current literature to indoor tanning. A strong literature for this supportive measures is an article that looks at subjects that test their knowledge, attitudes, and behaviors of indoor tanning spanning nineteen years. In this study, individuals were asked about the link between indoor tanning and skin cancer understanding. This article shows that the overall understanding association between indoor tanning and skin cancer had generally increased from 1988 to 2007 (Robinson et al., 2008). This is related to the PMT model because with a study that shows that people understand the consequences of indoor tanning, yet the consistency of young adult tanning could be mind-boggling.

Another piece of literature that could assist in placing the “fear” or perceived threat in indoor tanning is a first-hand experiences by a women who were indoor tanning and were diagnosed with melanoma. Many of these women had experienced indoor tanning at earlier ages and were diagnosed within young adulthood. Many of these women share their experiences and compare indoor tanning to other health behavior like smoking (Tavernise, 2015). This article is similar to a fear appeal that the FDA posted as a woman was diagnosed with melanoma at age 20 because of daily use in a tanning bed for almost 3 years (FDA, 2010). First-hand experiences are a great addition to understanding the PMT model. Many people do not see the danger until the damage has already been done.
A study that could be related to the PMT model is a study that considers indoor tanning an addiction following the DSM TR-IV criteria and a questionnaire. This article also looked into the subjects’ use of substance abuse and adjacent mental health disorders (i.e. anxiety, depression, etc.). This study shows associations between indoor tanning addictions and other addictions. In order to overcome, a tanning addiction the other addictions would also need to be addressed at some point. (Mosher & Burg, 2010). In a psychological standpoint, that some behaviors are linked from other behaviors especially when learning and succeeding in quitting.

A final article that could assist in understanding the PMT model is understanding the contextual factors and dependence that indoor tanning plays on individuals, more specifically young women. This study asked women how many times they visited the tanning bed and what the cost was for each visit, another crucial question asked how much time was spent in the tanning bed (Heckman et al., 2015). This article helps understand the answers to the question “why?” Why do people tan? Why is it hard to give up? These questions are answered in the corresponding articles, but overall a main reason that was listed in this article to indoor tan was to increase their mood and their self-esteem (Heckman et al., 2015). This shows that young adults are more comfortable to tan in an indoor tanning bed so then the chances of returning are increased as well.

A health program to help young adults change their minds and put away their tanning lotions and goggles, would follow a PRECEDE/PROCEED model. This model is two separate acronyms Predisposing, Reinforcing, and Enabling Constructs in Educational/environmental Diagnosis and Evaluation (PRECEDE) (DiClemente et al., 2012). The other acronym is Policy, Regulatory, and Organizational Constructs in Educational and Environmental Development (PROCEED) (DiClemente et al., 2012). The PRECEDE side of the model is specified for
measurable objectives and baselines; whereas the PROCEED side of this model is used to monitor and continue quality improvement (DiClemente et al., 2012).

The majority of this health program would be designed to help young adults by showing them the dangers and risks of indoor tanning through fear appeals and utilizing the PMT model. The goals of this program would to reduce the number of men and women between the ages of 18 and 25 using indoor tanning beds and provide the education and general understanding of skin cancer. It would be important to stress that skin cancer is skin cancer no matter the strength and even if the first case is mild it doesn’t mean that later in life a person would not be diagnosed with melanoma.

The strategy used to promote this health program would be to utilize major college cities and hold a seminar about the dangers of skin cancer. The population would first be gathered through a general, anonymous questionnaire that would direct them to this learning experience. This questionnaire would include how many days a week they indoor tan and how long they tan in each session. These are vital part to understanding the damage that is being done to the skin, as well as the increased risk of skin cancer.

During the seminar, personal stories of how indoor tanning has changed a person’s life would be involved as well as black lights that would show the damage to the skin. This would also print a picture for each participating individual to take home so that they are reminded of what an indoor tanning bed is doing to their skin every time they decide to bathe. At this seminar, free samples of sunscreens and skin moisturizers with sunscreen would be an added bonus because the lessons also learned that just because you gave up the bed doesn’t mean you can still put your skin through the rays of the sun. Those rays are just as dangerous, so protecting
your skin with sunscreen is the easiest thing anyone could do. The seminar would finish with any final remarks and last questions.

Even though the seminar portion is over, the overall health program is not over because evaluations over time would have to be done in order to see if the health program made a difference this could be as simple as resending the same questionnaire as before. There is an understanding that some results may be skewed and bias, but there would be no determining factors that they would all be intended to have that purpose.
REFERENCES


