

*Why bother promoting health when no one
cares to listen!*

THE HEALTH BELIEF MODEL

*Don't they realize that we just want them
to stay healthy?*

by

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We built it...

Model developed in 1950s (and subsequently expanded) to explain lack of public interest in programs to prevent and detect disease.

So why aren't they coming?!

*I think therefore, I am.
Or is it - I think, therefore I do?*

This is a model for individual health behaviour modification. It attempts to explain the thought processes that drive individuals' behaviours. As such, this model acts as a framework for designing health behaviour interventions.

I could quit smoking, and save lots of money. But I don't want to be crabby. That's a sure fire way to lose friends. So - I guess I'll stay a popular smoker!

This model essentially suggests that individuals engage in cost-benefit analyses, and their conclusions drive behaviours and choices.

CONSTRUCTS

There are 6 main points that individuals consider in their cost-benefit analyses.

Perceived Susceptibility

Men don't get breast cancer, so of course I don't need a mammogram!

Perceived Severity

A cold isn't a big deal! Why the heck should I do the "sleeve sneeze" and ruin my cashmere sweater!

Perceived Benefits

Oh, I'm all for health. What's in it for me though? Can I win a car if I quit smoking? I'd like that.

Perceived Barriers

Do you have any idea how my coffee tastes with only one teaspoon of sugar in it? Its so bitter, and if I can't drink it I am crabby all day. And no one needs to witness that.

Cues to Action

You know, I never used to wash my hands going into a patient's room.

The sanitizer is right beside the door now so there is no way I can forget. I suppose it helps that the patients have also been told to ask if I washed my hands!

Self-Efficacy

Today I bought my own underwear.
What a revelation! I feel that I can
buy anything now. Tomorrow I'll
even go buy some groceries.

Sorry mum, your son is doing it for
himself now!

Age: *23*

Gender: *Female*

Ethnicity: *Canadian*

Personality: *Type Eh!*

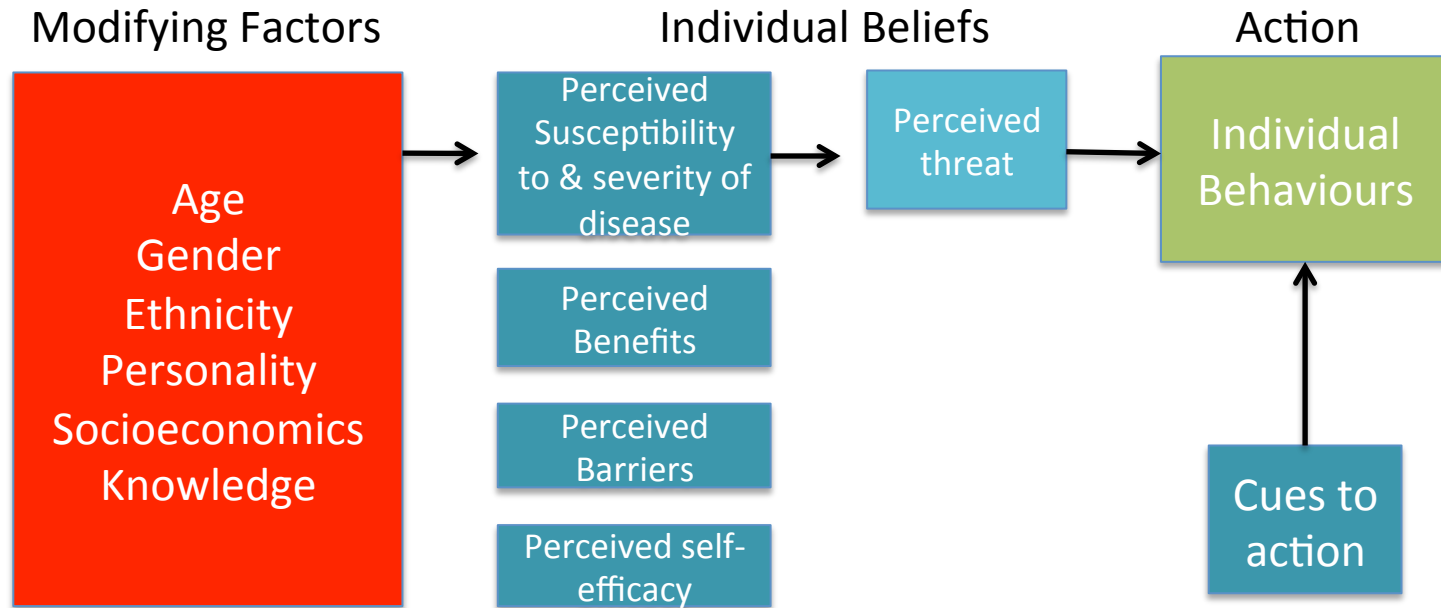
Socioeconomics: *Too rich for you!*

Knowledge: *"I am so smart, SMRT..."*

MODIFYING FACTORS

Other factors influence perception and behaviour change, and maintenance of new behaviours. These variables can be related to demographics, the psychosocial, as well as the structural.

HBM CONNECTIONS AND LINKAGES



* Relationship between and among constructs not defined

*Oh my god! I love cake! I always take
the elevator! I need three creams in
my coffee! I am totally going to be a
Dia-betty..., aren't I?!*

PERCEIVED THREAT

perceived susceptibility x perceived severity

EVIDENCE FOR HBM'S PERFORMANCE

- Most powerful single predictor: perceived barriers
- Also important: perceived susceptibility & benefits
 - Perceived susceptibility stronger predictor of preventative health behaviour
 - Perceived benefits stronger predictor of sick-role behaviour
- Least powerful predictor: perceived severity

*BE CONSISTENT! BE SPECIFIC! BE
RELEVANT! BE THOROUGH!
AND FOR CHRIS SAKES BEHAVE!*

MEASURING HBM

- Construct definitions need to be consistent with HBM theory
- Measures need to be specific to behaviour being addressed
- Measures need to be relevant to the population on which they will be used
- The full range of factors that can influence a behavior have to be addressed to ensure content validity

I honestly wonder if they realize that I don't "rate" my fears. That requires me to look at them! I prefer to just run!

LIMITATIONS

- Relationship between perceived severity and susceptibility not clear – perceived susceptibility may be dependent on level of severity
- Relationships between other constructs needs to be tested more thoroughly (e.g. threat may not need to be high if barriers are low)
- Does not consider emotional component of behaviour → fear
- Cues to action are not well studied

DISCUSSION QUESTION

Why is the model called the "Health Belief Model"? What sort of health and belief were the creators of the model referring to?