

Theories of Individual Health Behavior Decisions

Be precise and explicit about what you want to understand. It is critical to successful research that you are very explicit and precise about the general class or type of behavior that you want to explain. Here is what I mean by being explicit and precise.

I first present three theories commonly used to understand **individual health behavior decisions**. I would point out that all of these theories are also used to explain other kinds of behavioral decision-making. These are not just theories of “health decisions,” but rather theories that explain **behavioral decision-making in general**, including health behavior decisions. Look at the theory of planned behavior, for example. The construct of self-efficacy can refer to virtually any behavioral decision. I chose to present these theories and define the constructs as they are commonly presented when the theory is applied to explain health decisions to make it easier for you to directly compare the constructs and linkages proposed in the theories, but they are not **just** theories of health behavior. These theories do not explain behaviors that do not involve decision-making – e.g., psychotic behavior. Second, note that these are theories that deal with **individual decision-making**, not group decision-making. There are many theories that try to explain group decision-making in general, including community and group models of health behavior. Examples include innovation diffusion theory, several theories of organizational change, and social marketing theory. The theory of planned behavior, does **not** explain group decision-making. So, overall, we can say that the general class of behavior that the three theories presented below describe is “individual, behavioral decision-making.” In fact, in most instances, these theories explain the decision to **change behavior**.

There are at least two other **groups** of theories that are commonly applied to understand health behaviors. The first are the **interpersonal health behavior theories**. While these theories also ultimately try to explain why an individual does or does not engage in a specific health behavior, they differ from the individual health behavior decisions in two key respects. First, they incorporate larger social forces (friends, family, etc.) as a primary factor in determining health behavior. Fundamentally, these three theories posit social relationships as a very powerful set of forces driving behavior. It is not that they argue that the individual does not act as a decision-maker, rather, they see the individual’s behavioral outcomes as a component in a larger social process. Second, not surprising perhaps, these theories focus less on decision-making. Again, these theories do not deny that decision-making occurs, rather they see cognitive or “purposeful” decision-making as just one factor that influences behavior, rather than, in many cases, the primary factor. Finally, a third group of theories relevant to health behaviors are derived from theories of community and organizational development. They focus much more on community or group level health outcomes and place the individual health behaviors within the context of larger social groups.

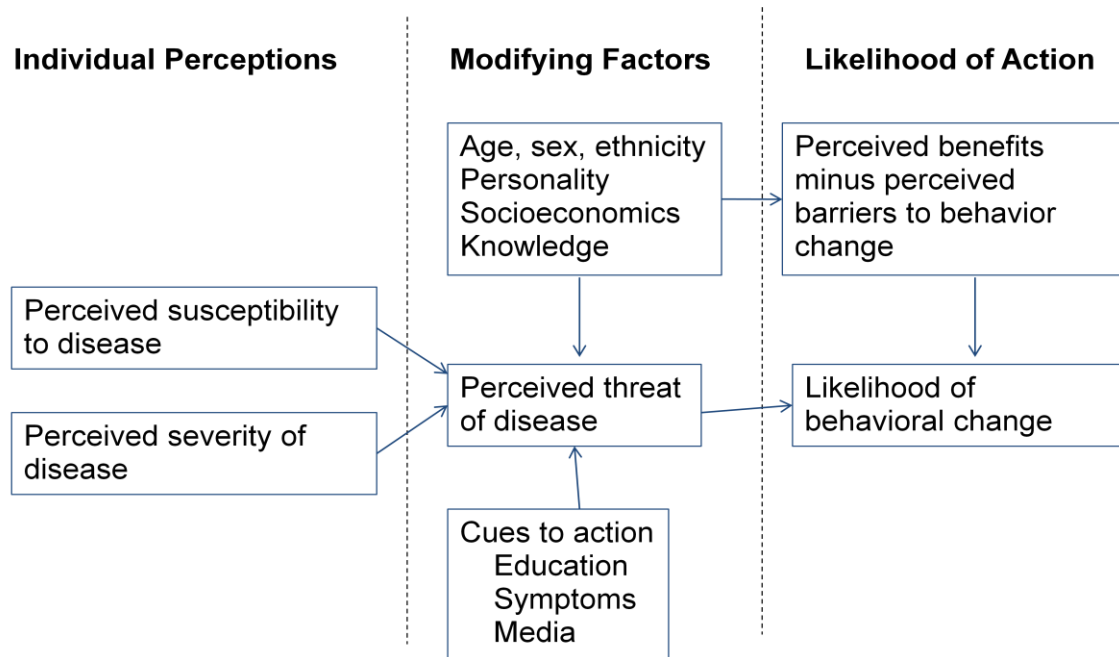
Be knowledgeable about the relevant theories. It is critical that you understand that your first step in the research process is to become knowledgeable about the theories that are relevant to the topic or subject of your research, e.g., in our example adolescent obesity. You do that by reviewing the published research reports based on the theories – by evaluating the existing, published evidence that supports the validity of the theory as an adequate explanation. There is **NO** substitute for knowing the research literature.

Select a theoretical framework appropriate for your research objectives. There are, in my experience, three common objectives for research. One is to **test theory**, e.g., to evaluate the degree to which a theory adequately explains something usually under a different set of conditions, with a different group of people, or at a different stage in the life cycle of people (families, communities) than those under which it has already proven successful in explaining the phenomenon of interest. Although theory

testing is discussed at great length in the literature about research design and methods, my personal view is that this often not the research objective among social scientists. The second is to **build theory**. This, I believe, is a very common research objective for social scientists. Theory building commonly involves clarifying the relationships among constructs and, in some cases, adding new constructs to see if they enhance the theory's explanatory power (e.g., how well it "performs" as an explanation). For example, if you look at the third theory presented here, the transtheoretical model, you will see that social liberation is a construct in the theory, but that it does not appear in the diagram (model) of the theory I offer. That's because no one has really figured out where it "goes" in the diagram – no one has been very successful in establishing its linkage to the other constructs. Theory building could focus on this construct to enhance our model of this theory. The third objective is to compare the explanatory power of two or more theories. This is often a very fruitful research objective. At the least, it allows us to draw some conclusions about the relative explanatory power of the theories used. Often, this kind of research allows us to bring together two or more theories to create a new, more elaborate theory, to resolve differences in the theories about where constructs "fit" in the model, or in some cases to incorporate constructs from one theory into another. For example, self-efficacy or control beliefs of some sort are a construct in all three of these theories. A researcher could fruitfully try to determine if these constructs all "mean the same thing," and if they do, help us clarify the commonalities among these three theories. You will have to decide in your research which of these three research objectives best fits your work. **Then** you will be ready to select a theoretical framework for your work. It may be a single theory or a combination of two or more theories. Whatever your decision, you **cannot create a research instrument** without a theoretical framework.

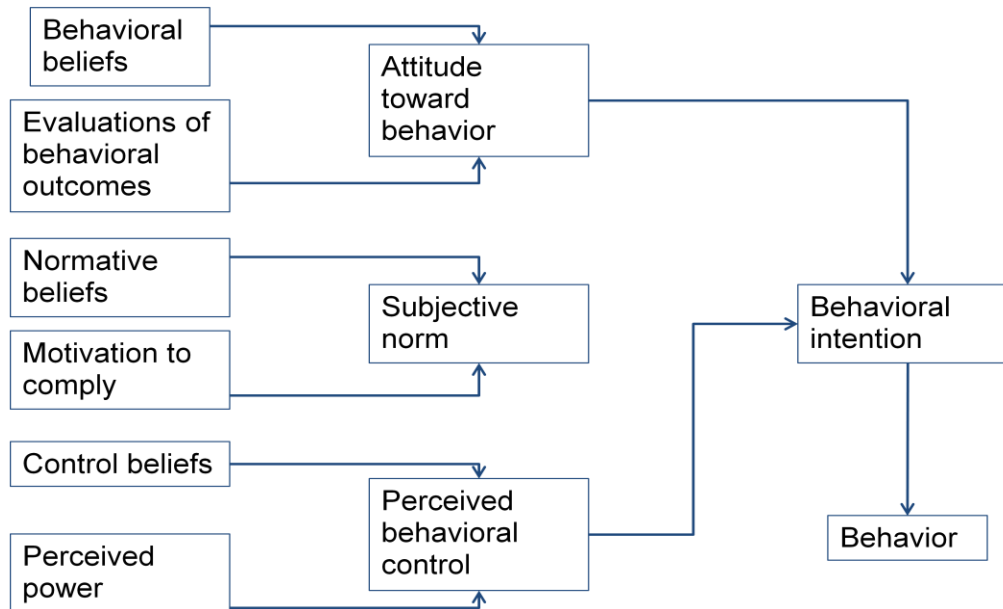
Health Belief Model

Construct	Definition
Perceived susceptibility	One's belief regarding the chance of getting a condition
Perceived severity	One's belief of how serious a condition and its consequences are
Perceived benefit	One's belief in the efficacy of the advised action to reduce risk or seriousness of impact
Perceived barriers	One's belief about the tangible and psychological costs of advised action
Cues to action	Strategies to activate one's "readiness" to act
Self-efficacy	One's confidence in one's ability to take the advised action



Theory of Planned Behavior

Summative or Direct Constructs	Primary or Indirect Constructs	Definition
Attitude toward behavior		Overall evaluation of the behavior
	Behavioral belief	Belief that behavioral performance is associated with certain attributes or outcomes
	Evaluation	Value attached to a behavioral outcome or attribute
Subjective norm		Belief about whether most people approve or disapprove of the behavior
	Normative belief	Belief about whether each referent approves or disapproves of the behavior
	Motivation to comply	Motivation to do what each referent thinks
Perceived behavioral control		Overall measure of perceived control over the behavior
	Control Beliefs	Perceived likelihood of occurrence of each facilitating or constraining condition
	Perceived Power	Perceived effect of each condition in making behavioral performance difficult or easy
Behavioral intention		Perceived likelihood of performing the behavior



Transtheoretical Model of Individual Health Behavior

Summative Construct	Primary or Indirect Construct	Definition
Stages of change	Precontemplation	Has no intention to take action within the next 6 months
	Contemplation	Intends to take action within the next 6 months
	Preparation	Intends to take action within the next 30 days and has taken some behavioral steps in this direction
	Action	Has changed overt behavior for less than 6 months
	Maintenance	Has changed overt behavior for more than 6 months
Decisional balance	Pros	Benefits of changing behavior
	Cons	Costs of changing behavior
Self-efficacy	Confidence	Confidence that one can engage in the healthy behavior across different challenging situations
	Temptation	Temptation to engage in the unhealthy behavior across different challenging situations
Process of change	Consciousness raising	Finding and learning new facts, ideas, and tips that support the healthy behavior change
	Dramatic relief	Experiencing the negative motions (fear, anxiety, worry) that go along with unhealthy behavioral risks
	Self-reevaluation	Realizing that the behavior change is an important part of one's identity as a person
	Environmental reevaluation	Realizing the negative impact of the unhealthy behavior or the positive impact of the healthy behavior on one's proximal social and physical environment
	Self-liberation	Making a firm commitment to change
	Helping relationships	Seeking and using social support for the healthy behavior change
	Counter-conditioning	Substituting healthier alternative behaviors and cognitions for the unhealthy behavior
	Reinforcement management	Increasing the rewards for the positive behavior change and decreasing the rewards of the unhealthy behavior
	Stimulus control	Removing reminders or cues to engage in the unhealthy behavior and adding cues or reminders to engage in the healthy behavior
	Social liberation	Realizing that the social norms are changing in the direction of supporting the healthy behavior change

Stages of Change

