

HEALTHY LIVING



- **THEORIES OF HEALTH BELIEF**
- **METHODS OF HEALTH PROMOTION**
- **ADHERENCE TO MEDICAL REGIMES**

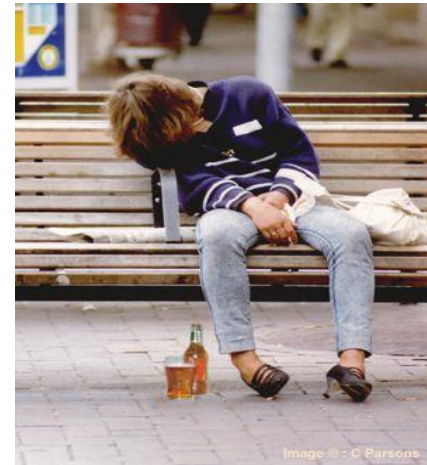
THEORIES OF HEALTH BELIEF

- Health psychologists are concerned with why individuals adopt certain health behaviours or have unhealthy lifestyles.
- What explanations can you think of?
- **Cognitive Theories:**
- **The Health Belief Model (HBM)**
- **Locus of Control**
- **Self-Efficacy**



THE HEALTH BELIEF MODEL: BECKER & ROSENSTOCK (1984)

- Theory to suggest how likely it is that someone will carry out a health protective behaviour
- Two assessments:
 1. **Evaluating the threat:**
 2. - perceived seriousness
 - perceived susceptibility
 2. **Cost- Benefits Analysis:** Do the costs of adopting behaviour outweigh the benefits?
 - Influencing Factors: - **Demographic variables** (age, income, sex, education, etc)
 - **External / internal cues** (advertising, period of illness, etc)



THE HEALTH BELIEF MODEL: EVALUATION ISSUES

LOCUS OF CONTROL: ROTTER (1966)

- How much **control** you perceive you have over your behaviour, environment or health.
- People differ in their beliefs about the control they have over their health:
- **External locus of control**: health is controlled by outside forces (eg; doctors, parents, fate, religion, etc)
- **Internal locus of control**: health is under personal control.
- What difference do you think different LoC would have for health behaviours?
- **Research**: Review article (**Rotter, 1966**): Internal V External LoC. (see text)
- Findings indicated the benefits of internal LoC in health (eg; smokers quitting behaviour)

SELF-EFFICACY: BANDURA (1977)

- The belief that you can perform adequately in a particular situation.
- In health: how successfully you think you could carry out healthy behaviours (eg:.....?)
- Self-efficacy primarily influenced by achievements
- Other Key Factors affecting self-efficacy:
 1. Observations of others performances (vicarious)
 2. Social & self persuasion
 3. Emotional arousal (eg; anxiety)
- **Research: Bandura & Adams (1977): Self-efficacy in snake phobics undergoing systematic desensitisation.** (see p.84; Heinemann)

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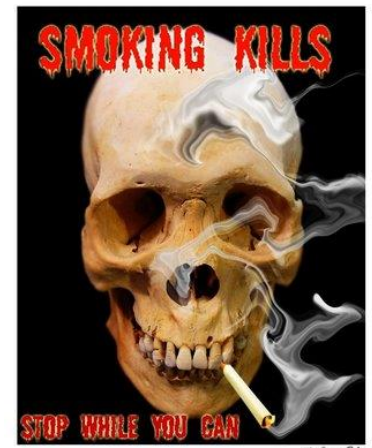
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EVALUATING THEORIES OF HEALTH BELIEF

- **Cognitive Theories**
- **Reductionism**: these theories all assume that thought processes are responsible for health behaviour yet this is too simplistic. Biological & social factors (eg;.....??) also influence our actions.
- **Validity**
- **Usefulness**

METHODS OF HEALTH PROMOTION

- Three methods of health promotion to learn about:
- **Media Campaigns:** TV, newspapers, radio, etc.
- **Legislation:** using laws to prohibit or enforce behaviours
- **Fear Arousal:** increasing impact of campaigns with fear (link to 'perceived seriousness' in HBM)



MEDIA CAMPAIGNS



- How successful are media campaigns?
- Can they change behavioural patterns related to health?
- **KEY STUDY: COWPE (1989): Chip-pan fires**
- **Aim:** to test effectiveness of TV safety campaign
- **Method:** Quasi-experiment: media campaign shown in 10 regional TV areas (1976 - 1984). Number of chip-pan fires analysed, consumer survey
- TV Campaign: Two 60 second commercials
- **Findings:** - Decline in fires: Eg; 7% (Central TV), 25% (Granada) & 33% (Tyne Tees).
Questionnaires: Increase in awareness (eg; 62% to 90% in Yorkshire TV area)
- * **Conclusion:** Effective campaign: behaviour change (see Heinemann p. 86)

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LEGISLATION



- Laws vary from country to country (eg; alcohol & driving) & success may depend on enforcement.
- **KEY STUDY: DANNENBERG et al (1993): Bicycle helmet laws (Maryland, USA)**
- **Aim:** Review impact of legislation on wearing cycle helmets in children (7322 children from 47 schools in Howard county, & two control groups (two other counties; one with educ.campaign). Aged 9 - 15)
- **Method:** natural experiment. Maryland law: children under 16 to wear cycle helmet. Questionnaires with likert scale (topics: bicycle use, helmet use, awareness of law, peer pressure, etc)

Dannenberg et al (continued)

- **Findings:** Response rates between 41 & 53%
 - Howard county: helmet usage increased from 11.4 to 37.5% (control counties; only small increase to approx 12%)
 - Howard County; most aware of law (87%)
 - Younger children most adherent

- **Conclusion:** Legislation produced large increase in reported helmet use.
Effective(?)



- (NB: self-reports correlated with observational study)

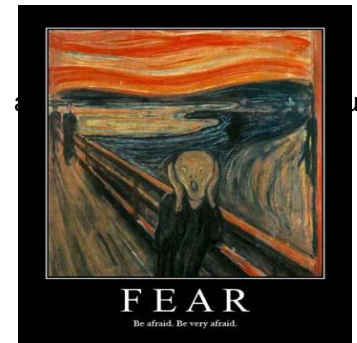
FEAR AROUSAL

- What frightens you about poor health?

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- How could you show someone the consequences of their unhealthy behaviour in a way that would frighten them into changing?
- Do fear appeals always work??



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KEY STUDY: JANIS & FESHBACH (1953)

- **Fear Arousal & Dental Hygiene**
- **Laboratory Experiment:** Showing fear-arousing material & using questionnaires to collect emotional reactions & changes to dental practice.
- **Participants:** US high school students (mean age 15yrs)
- **Independent Measures design:** 3 groups:
- **Group 1: Strong fear appeal**



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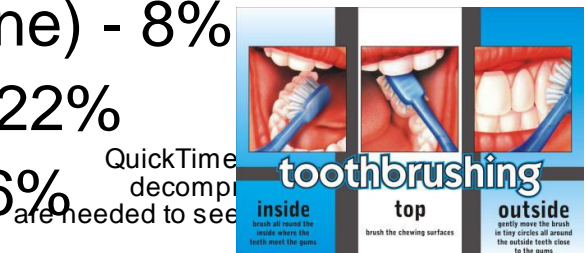


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- **Group 2: Moderate fear appeal**
- **Group 3: Minimal fear appeal**
- (Control group: lecture on human eye function)

JANIS & FESHBECK (1953) CONTINUED

- Procedure:
 - Questionnaire given one week before lecture
 - 15 minute lecture using same lecturer
 - Questionnaire for immediate emotional reactions
 - One week later: questionnaire on long term effects
- Findings:
 - **Strong fear appeal:** more interesting but more dislike. Conformity (change to dental hygiene) - 8%
 - **Moderate fear appeal:** conformity - 22%
 - **Minimal fear appeal:** conformity - 36%
- **Conclusion:** Important that level of fear appeal is right for audience. Low fear appeal may be optimal level



FEATURES OF ADHERENCE TO MEDICAL REGIMES

- Health psychologists need to consider why people do not adhere to medical advice.
- Three areas to study:
- **Reasons for Non-adherence** (rational non-adherence)
- **Measures of Non-adherence** (physiological)
- **Improving Adherence** (behavioural)

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REASONS FOR NON-ADHERENCE:

COGNITIVE RATIONAL NON-ADHERENCE

- **Rational non-adherence:** logical decision not to adhere to medical advice. Link to [HBM](#) (costs-benefits analysis)
- **KEY STUDY: BULPITT et al (1988): Importance of Well-being in Hypertensive Patients**
- **Review research** of problems with taking drugs for high blood pressure.
- **Qualitative data** collected:
physical & psychological effects
- **Findings:** side -effects:
sleepiness, dizziness & impotence.
15% patients withdrew from medication
- **Conclusion:** When costs outweigh benefits
- less adherence.



MEASURES OF NON-ADHERENCE:

- Consider how you could measure adherence

- Self-reports

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- Pill & bottle counts

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- Mechanical methods

- Biochemical tests

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- Strengths & weaknesses of above?

KEY STUDY: **LUSTMAN et al (2000):**

Use of Fluoxetine in treatment for depression in diabetes

- Assumes that treating depression will aid adherence
- **Controlled double-blind study**
- **Participants:** 60 patients with type 1 or type 2 diabetes, diagnosed with depression
- **Procedure:** Ps randomly assigned to Fluoxetine or placebo group. Psychometric tests to test for depression & Blood-sugar levels (GHb levels) measured for adherence to regime.
- **Findings:** Fluoxetine patients - lower levels of depression, & near normal levels of GHb
- **Conclusion:** Greater adherence in patients who are less depressed,



IMPROVING ADHERENCE: BEHAVIOURAL

- How could you improve people's adherence?
- **KEY STUDY: WATT et al (2003): Funhaler Spacer: Improving Adherence to Asthma Medication**
- **Method:** Experiment (field & quasi)
- **Participants:** 32 Australian children (10 boys/22 girls), mean age 3.2yrs
- **Procedure:** Repeated design:
One week using standard inhaler
One week using 'Funhaler'
Parent questionnaire at end of each week
- **Findings:** 38% parents medicated children more regularly using Funhaler.
- **Conclusion:** Making medical regime fun for children - increases adherence.



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