Overview of health behaviour theories

APPENDIX

HEALTH BEHAVIOUR THEORIES

‘ The biomedical perspective

The biomedical perspective incorporates the biomedical theory in which patients are assumed to be passive recipients of doctors’ instructions’.

‘ Behavioural (learning) perspective

This perspective incorporates behavioural learning theory (BLT) which is focused on the environment and the teaching of skills to manage adherence’.

‘ Communication perspective

Communication is said to be “ the cornerstone of every patient-practitioner relationship” [p. 56]. This perspective suggests that improved provider-client communication will enhance adherence and implies that this can be achieved through patient education and good health care worker communication skills – an approach based on the notion that communication needs to be clear and comprehensible to be effective. It also places emphasis on the timing of treatment, instruction and comprehension.’

‘ Cognitive perspective

The cognitive perspective includes theories such as the health belief model (HBM), social-cognitive theory (SCT), the theories of reasoned action (TRA) and planned behaviour (TPB) and the protection motivation theory (PMT). These theories focus on cognitive variables as part of behaviour change, and share the assumption that attitudes and beliefs, as well as expectations of future events and outcomes, are major determinants of health related

behaviour. In the face of various alternatives, these theories propose, individuals will choose the action that will lead most likely to positive outcomes.'

' Health Belief Model

The HBM views health behaviour change as based on a rational appraisal of the balance between the barriers to and benefits of action. According to this model, the perceived seriousness of, and susceptibility to, a disease influence individual's perceived threat of disease. Similarly, perceived benefits and perceived barriers influence perceptions of the effectiveness of health behaviour. In turn, demographic and socio-psychological variables influence both perceived susceptibility and perceived seriousness, and the perceived benefits and perceived barriers to action. Perceived threat is influenced by cues to action, which can be internal (e. g. symptom perception) or external (e. g. health communication).'

' The protection-motivation theory

According to this theory, behaviour change may be achieved by appealing to an individual's fears. Three components of fear arousal are postulated: the magnitude of harm of a depicted event; the probability of that event's occurrence; and the efficacy of the protective response. These, it is contended, combine multiplicatively to determine the intensity of protection motivation, resulting in activity occurring as a result of a desire to protect oneself from danger. This is the only theory within the broader cognitive perspective that explicitly uses the costs and benefits of existing and recommended behaviour to predict the likelihood of change.'

‘ Social-cognitive theory

This theory evolved from social learning theory and may be the most comprehensive theory of behaviour change developed thus far. It posits a multifaceted causal structure in the regulation of human motivation, action and well-being and offers both predictors of adherence and guidelines for its promotion. The basic organising principle of behaviour change proposed by this theory is reciprocal determinism in which there is a continuous, dynamic interaction between the individual, the environment and behaviour.’

‘ Theory of planned behaviour and the theory of reasoned action (TRA)

The first work in this area was on the TRA.

The TRA assumes that most socially relevant behaviours are under volitional control, and that a person’s intention to perform a particular behaviour is both the immediate determinant and the single best predictor of that behaviour]. An intention to perform a behaviour is influenced by attitudes towards the action, including the individual’s positive or negative beliefs and evaluations of the outcome of the behaviour. It is also influenced by subjective norms, including the perceived expectations of important others (e. g. family or work colleagues) with regard to a person’s behaviour; and the motivation for a person to comply with others’ wishes. Behavioural intention, it is contended, then results in action.’

‘ Information-motivation-behavioural skills (IMB) theory

This theory was developed to promote contraceptive use and prevent HIV transmission. IMB was constructed to be conceptually based, generalisable

and simple. It has since been tailored specifically to designing interventions to promote adherence to ART.'

' Self-regulation perspectives

Self-regulatory theory is the main theory in this domain. Developed to conceptualise the adherence process in a way that re-focuses on the patient, the theory proposes that it is necessary to examine individuals' subjective experience of health threats to understand the way in which they adapt to these threats. According to this theory, individuals form cognitive representations of health threats (and related emotional responses) that combine new information with past experiences.'

' Stage perspectives

The transtheoretical model (TTM)

This theory is most prominent among the stage perspectives. It hypothesizes a number of qualitatively different, discrete stages and processes of change, and reasons that people move through these stages, typically relapsing and revisiting earlier stages before success. This theory is said to offer an " integrative perspective on the structure of intentional change" [p. 1102] – the perceived advantages and disadvantages of behaviour are crucial to behaviour change.'

Lakhan, 2006