

Health Behavior

Through much of its history, medical sociology has directed far more attention to disease and illness than to health and wellness. Today, medical sociologists, like the medical profession and society and general, are seeking more balance in their focus and are studying health more closely.

This expanded focus has produced some important questions. What does it mean to be “healthy” or “well”? How does society encourage healthy lifestyles? To what extent do people engage in behaviors that will promote health—or, at least, not engaged in health-damaging behaviors? And, what are the strongest influences on participation in these positive and negative health behaviors?

THE CONCEPT OF HEALTH

Defining **health** may appear to be quite simple, but there is no consensus about what constitutes a “healthy” person. Three main approaches exist for defining health: the biomedical approach, the psychological approach, and the sociological (or sociocultural) approach.

The Biomedical Approach

The traditional **biomedical definition of health** focuses solely on the individual’s physiological state. *Health* is defined simply as the absence of disease or physiological malfunction: it is not a positive state, but the absence of a negative state—if you’re not sick, you’re well. According to Wolinsky (1988), the biomedical model makes four primary assumptions that limit its utility for completely understanding health and illness:

1. The presence of disease, its diagnosis, and its treatment are all completely objective phenomena—that symptoms and signs provide accurate and unbiased information from which valid diagnosis can unfailingly be made. However, this assumption is faulty. For example, studies have found that individual’s cultural background affects not only the reaction to symptoms but also how these symptoms are reported to physicians and that the presentation of symptoms can influence diagnosis.
2. Only medical professionals are capable of defining health and illness. In reality, however, both the patient and her or his significant others are involved in the process. While one must not discount the power that society has granted to physicians for defining health and illness, a great deal of diagnosing and treatment occur outside the physician’s office.
3. Health and illness should be defined solely in terms of physiological malfunction. In fact, people are not merely biological beings; they are also psychological and social creatures, and state of health is affected by all three aspects.
4. Health is defined as merely the absence of disease. This focuses attention on the malfunctioning part of the organism but excludes the rest of the positively functioning being. Thus, much may be learned about disease, but little is known about health.

The Psychological Approach

The **psychological definition of health** asserts that individuals constantly make subjective evaluations of their own health. While this assessment of psychological wellness gives attention to one's overall feeling of well-being, it also includes: (1) *pleasurable involvement*, including the good feelings associated with personal accomplishments, receiving compliments, and interesting daily activities; (2) *long-term satisfaction*, including the longer lasting happiness associated with positive personal, familial, and work situations; and (3) the absence of *negative affect*, including unhappiness, loneliness, and criticism from others. Research has affirmed that positive and negative processes are distinct psychologically and often are not highly correlated. Being happy involves more and is different from not being sad; an individual could be both (or neither) happy and sad simultaneously.

The Sociological Approach

The **sociological definition of health** emphasizes the social and cultural aspects of health and illness. This approach focuses on the individual's capacity to perform roles and tasks in everyday living and acknowledges that there are social differences in defining health.

Capacity to Perform Roles and Tasks. Objecting to the biomedical definition, Talcott Parsons suggested that health be viewed as the ability to comply with social norms. He defined health as "the state of optimum capacity of an individual for the effective performance of the roles and tasks for which he has been socialized." Note that almost completely opposite of this definition to the biomedical approach: No assumption is made that disease can be objectified; the focus is much broader (and more socially relevant) than mere physiological malfunctioning; the individual's own definition of his or her health is given centrality (rather than the physician's definition); and the definition is states in positive terms. According to this approach, health is not just the lack of something—it is a positive capacity to fulfill one's roles; it is not just a physiological condition—it includes all the dimensions of individuals that impact on social participation.

Social Differences in Defining Health. Twaddle (1974) sees health as being defined more by social than physical criteria. He views health and illness as being on a continuum between the perfect state of health and the perfect state of illness (death). While "normal" health and illness fall somewhere between the two extremes, what may be considered a healthy state for one person may be considered unhealthy by another. Perception of health is relative to one's culture (e.g., being 10 pounds overweight is suggestive of ill health in some cultures but is socially approved in others) and one's position in the social structure (e.g., back pain that may cause a salaried worker to miss a day of work might be ignored by an hourly wage worker) and is influenced by social criteria.

Research has demonstrated that social factors do influence how individuals define personal health status. For example, data from the Health and Lifestyle Survey, a national survey of men and women living in England, Wales, and Scotland, show that personal definitions of health vary by age, gender, and perceived level of health.

Younger men conceptualize health in terms of physical strength and fitness, whereas their female counterparts are more focused on energy, vitality, and the ability to cope. Older men and women consider health in terms of function as well as a state of contentment and happiness. Women of all ages often include social relationships in their definitions while men rarely do so.

The World Health Organization (WHO) Definition

The WHO takes an inclusive approach by defining health as a state of complete physical, social, and mental well-being. This definition suggests that health relates to one's ability to cope with everyday activities and to being a fully functioning human being—physically, socially, and emotionally. In this sense, health is a resource for everyday life. It is a positive concept emphasizing social and personal resources as well as physical capacities.

HEALTH BEHAVIOR

When medical sociologists first began to study **health behavior**, they conceptualized it as activity undertaken by an individual believing himself or herself to be healthy for the purpose of preventing health problems. In recent years, sociologists have recognized that health behavior actually consists of several dimensions and types of activities. Researchers have identified four separate dimensions:

1. *Prevention.* The goal of **prevention**, or preventive health behavior is to minimize the risk of disease, injury, and disability. These “health-preventive behaviors” include participating in regular exercise, maintaining a favorable weight and healthy diet, not smoking or using illicit drugs, and obtaining immunizations against communicable diseases.
2. *Detection.* **Detection** involves activities to detect disease, injury, or disability before symptoms appear and includes medical examinations (such as taking the blood pressure) or screenings for specific diseases.
3. *Promotion.* **Health promotion activities** consists of efforts to encourage and persuade individuals to engage in health-promoting behaviors and to avoid or disengage health-harming behaviors.
4. *Protection.* **Health protection activities** occur at the societal rather than the individual level and include efforts to make the environment in which people live as healthy as possible. Doing this involves monitoring the physical and social environments in which people live; physical structures and infrastructures; systems of transportation; available food, air, and water; places of work; and developing social and economic policies that permit and encourage good health.

DESCRIBING INDIVIDUAL HEALTH BEHAVIORS

Prevention

Health-protective behaviors (HPBs) are individual actions taken to protect, promote, or maintain health. These actions are both *prescriptive* in nature (e.g., eat a nutritious diet, wear a seat belt when in a car, get adequate exercise) and *proscriptive* (e.g., avoid unsafe driving, smoking, and excessive alcohol consumption).

Detection

Today, a wide range of health screening procedures are available, including periodic physical examination, eye and dental examinations, blood pressure and cholesterol readings, prenatal and well-baby care, and screenings to detect cancer. Much research has demonstrated considerable health and cost benefits of participation in these services.

Correlates of Participation in Detection Services. Because these detection services are so effective, the question becomes why more people do not use them. One important reason is that the cost of some of these services discourages participation by people with low incomes and inadequate or no health insurance. In the United States, low-income women receive one-third less prenatal care, and children from poor families are only one-fourth as likely as children in non-poor families to have a routine physical examination. Similarly, many poor parents forgo any medical contacts for themselves so whatever funds are available can be used for their children. Research on families who receive services at free health clinics—where services are offered at no charge by volunteer physicians and dentists—has found that many parents bring children to the clinic for preventive or therapeutic care but do not ask to be seen themselves. Often, when staff inquire, the parent acknowledges having some medical problems that could be addressed by clinic staff. But, the parent has become so accustomed to doing without medical care that no request for personal services is made.

EXPLAINING HEALTH BEHAVIOR

In the late nineteenth century, Max Weber identified both *macro* factors (social-structural conditions) and *micro* factors (personal choices) as being important influences on the formation of lifestyle. He referred to the impact of social-structural conditions as “life chances” and the impact of personal choices as “life conduct” and argued that they are interlinked and interdependent. One researcher points out that the interdependence of life chances and life conduct is particularly insightful in relation to health and illness. After all, certain life chances (e.g., income) influence individual health behaviors, and certain behaviors (e.g., substance abuse) are health-damaging and can harm one’s life chances. In the United States, without question, more attention has been directed to examining participation in health behaviors from the micro perspective.

The Macro Approach. Several medical sociologists have criticized the almost exclusive focus that policy makers and the general public have given to personal choices and individual behaviors in considering health behaviors. John McKinlay argues that with regard to preventive health action, we have spent most of our time downstream being preoccupied with encouraging people to avoid risky behavior, while we have neglected the agents, social circumstances, and structural arrangements upstream that create the options of risky behavior. He states that significantly greater impact on health occurs with legislative acts that raise taxes or restrict advertising on cigarette manufacturers than a multitude of efforts to persuade individual smokers to quit. Yet most efforts are directed downstream at the individual smokers rather than upstream at the tobacco industry.

Reasons for Lack of Attention to Macro Factors. Why is so little attention devoted to macro-level factors? At least three factors seem important. First, using social policy and the force of laws to regulate individual behavior is viewed by some as contradicting the cultural value of individualism. One researcher points out that people are willing to cede to the government prevention activities that they cannot do for themselves—for example, inspecting the safety of each bridge. But, people are more reluctant to empower the government to protect us from our own behaviors. Many believe that allowing the government to go too far upstream oversteps its legitimate role in a free society.

Second, the value of individualism carries over into the political economy. Donahue and McGuire (1995) use the term *marketplace strategy* to describe the view that the government's primary obligation is to stay out of the marketplace so that individual consumers can exercise their own judgment about what to purchase and how to live. Of course, the view that the medical marketplace is completely open is inaccurate. Corporations and the government itself very much influence health (e.g., through the location of toxic dumps), corporations contribute sizable amounts of money to political candidates each year hoping to influence the political process. For example, in recent years, the tobacco industry has contributed millions of dollars each year to the political campaigns of members of Congress. Whether these contributions have influenced the Congress's refusal to increase the cigarette tax—a measure with broad social support—can only be surmised, but the more money a member received, the less likely he or she was to support tobacco control legislation.

Third, the absence of attention to macro-level factors enables society to forgo dealing with the wealth of research that establishes a direct relationship between individuals' social and physical environment and their health status. Studies have shown that even a small increase in years of education for an individual—or in average years of education for a population—has a greater impact on health than the available quantity of health resources. But, by focusing on the individual, and solely affixing responsibility for health behavior at that level, the important effects of poverty and unemployment, racism, and lack of educational opportunity can be ignored.

The Micro Approach.

The importance of macro-level factors does not negate the importance of understanding the factors that influence individual decisions about health behaviors. Several micro-level theories have been developed to explain health behavior.

The Health Belief Model. The **Health Belief Model (HBM)** provides a paradigm for understanding why some individuals engage in health-protective behaviors, while others behave in a knowingly unhealthy ways. The model recognizes that, in making health decisions, individuals consider both health-related and non-health-related consequences of behavior.

Development of the Health Belief Model was sparked by concern of many public health researchers in the 1950s and 1960s that few people were altering their behavior (e.g., ceasing to smoke) despite public health warnings. Development by a group of social psychologists, the basic premise of the HBM is that the likelihood of engaging in preventive health behavior is influenced by certain beliefs about a given condition (such

as developing cancer) rather than by objective facts. The HBM asserts that individuals will take preventive health actions only when the following four conditions exist: (1) the individual feels susceptible or vulnerable to a certain disease or condition; (2) the individual feels that contracting the disease would have serious consequences; (3) the individual believes that taking the preventive action would reduce susceptibility to the disease (or at least reduce its seriousness if contracted) and that the action would not involve serious barriers (e.g., inconvenience, expense, pain, or trauma); and (4) one or more cues or triggers for action (e.g., media attention, advice from others, a physician reminder, or an illness of a family member or friend) occurs).

All of these perceptions can be influenced by several nonhealth factors including demographic (age, gender, social class, race/ethnicity), sociopsychological (personality, peer and reference group pressure), and structural (knowledge about the disease, prior contact with the disease) factors.

The Health Belief Model has shown to be an effective predictor of preventive health action in studies focusing on such behaviors as breast self-examination, patient compliance with regimens, getting an influenza vaccination, seeking dental care, dietary compliance among obese children and cigarette abandonment. These studies have shown that taking preventive health action is more likely when perceived vulnerability to a serious disease or illness is high and when preventive health action is perceived to be effective in avoiding a negative outcome.

However, limitations of the HBM have also been identified. A key limitation is that the model is structured to focus on preventive health action relative to a particular disease or illness. To use this model, one must assess perceptions of a particular disease and perceptions of the efficacy of taking action to prevent that disease. Although the model has been helpful in examining these disease-specific behaviors, it is less applicable to understanding preventive health actions in general or in predicting the likelihood of engaging in general health-promoting behavior unrelated to fear of a particular disease.

The Health Belief Model and AIDS Risk and Reduction among Young People. The Health Belief Model has been used to explain why some young people voluntarily protect themselves against the deadly HIV infection while others remain knowingly vulnerable. Without question, many young people are at risk for AIDS. More than three-fourths of males and females have engaged in sexual intercourse by the age of 19. The high rate of pregnancy among teenagers and the very high rate of sexually transmitted diseases among the young testify to the lack of safe sex practices. In addition, a large majority of diagnosed cases of AIDS are people between the ages of 20 and 29. Given the incubation period, most of these people were infected during their teen years.

According to the HBM, individuals have differing perceptions regarding their susceptibility of infection as well as the seriousness of HIV/AIDS. For example, a gay male may feel particularly vulnerable due to the high incidence of AIDS in this group and may recognize its seriousness if he has witnessed the illness and death of friends. These perceptions must be complemented by information about the methods of transmission and the precautions that must be taken to avoid transmission.

However, individuals may still fail to take precautions. Some trust that medical technology will find a solution to the problem (which may be a reflection of incorrect

information as well as a form of denial of individual risk); others may not have been exposed to a triggering event (the death of a friend); and others may calculate that perceived barriers (sacrificing sexual pleasure) outweigh perceived benefits of preventive action. One must also feel capable of making recommended behavioral changes and believe that those changes will actually make a difference. In high-prevalence areas, some may continue to engage in unsafe practices because they believe they are already exposed.

A study of more than 300 introductory psychology students in California postulated that three factors (perceptions of personal vulnerability, sexual behavior history, and homophobia) would predict levels of worry about contracting a sexually transmitted disease, and, in turn, that worry would predict behavioral change to safer sex practices. These predictions were supported in the research, although somewhat different patterns were found for female and male students. For both females and males, worry was a strong predictor of risk reduction behaviors. However, only females were influenced by sexual behavior history (e.g., number of partners and having had a STD), and only males were influenced by perceived vulnerability and homophobia. Thus, gender was identified as a key influence on the processes within the HBM.

The Theory of Reasoned Action (TRA). Developed by Ajzen and Fishbein (1973), the central premise of the Theory of Reasoned Action is that intention or motivation to perform a behavior preceded actual performance of the behavior. The intention to behave in a particular way is influenced by attitude toward the behavior (how enjoyable or unenjoyable in this behavior?), social norms (is this an expected behavior in society?), messages conveyed by significant others (do others want me to engage in this behavior), and the importance to the individual of complying with the relevant social norms and wishes of others.

Actual participation in a preventive health action would be preceded by beliefs, attitudes, and norms that encourage that action and an intention to engage in it. Similar to HBM, background characteristics of the individual and certain personality and other social-psychological traits can be important influences. Unlike the HBM, TRA is almost entirely rational and does not include a significant emotional component (like perceived susceptibility to disease). In addition, TRA includes much more explicit consideration of social influences by incorporating the wishes of significant others for the individual to comply with these wishes.

The Theory of Reasoned Action and the Cessation of Smoking. Although TRA has not in general been as successful as the HBM in predicting preventive health actions, it had been more effective in predicting smokers who would attempt to stop smoking. One study that was based on a general household survey determined that behavioral intention was a critical precursor to actual attempts to cease smoking and that it was a more powerful predictor than any of the individual items in the HBM. Although the researchers preferred the HBM for other reasons, they concluded that the intention to engage in preventive health action is an important influence of the action.

Other Social-Psychological and Social-Structural Influences. Three additional variables with potential explanatory power for health behavior have been studied. The

underlying theory of **health of locus of control (HLC)** is that healthy behaviors are selected by individuals based on the expectation that they will actually lead to positively valued health outcomes. That is, those who feel they have control over their own health (internal locus of control) are more likely to engage in health-protective behavior than those who feel powerless to control their own health and believe health to be determined by luck, chance, or fate (external locus of control).

Some research shows that persons with an internal locus of control are less likely to smoke and use alcohol and other drugs and are more likely to engage in personal health-screening activities, but many studies have failed to find locus of control to be an important predictor of health behaviors.

Several studies have shown that the value that individuals attach to their health helps to predict participation in health behaviors—those who prioritize good health are more likely to lead a healthy lifestyle. In some recent studies, researchers have examined health locus of control in conjunction with a measure of *value of health*. Theoretically, behaviors followed by reinforcements high in value are more likely to be learned and repeated. Therefore, it is reasonable to expect that internal locus of control beliefs would predict HPBs only for people who place a high value on their health.

Some studies have found that internally controlled individuals who place a high value on health are more likely than others to quit smoking and to have good eating habit, but other studies have not detected this relationship. Thus, although HLC and health value are intuitively appealing, research thus far has found that they have only modest ability to predict health behavior.

Several studies have shown that individuals engaged in ongoing interpersonal relationships with family members, friends, and co-workers (*social support*) are more likely to participate in health-protective behaviors. Among adults, this often occurs as significant others attempt to influence and persuade the individual to practice healthy lifestyle. For example, among a group of employees enrolled in a worksite health promotion program, friends, relatives, and co-workers were positive influences in changing health-related behaviors initially, and in encouraging subjects to maintain these changes over time. This pattern of influence also occurs within marriages, although wives are more likely to try to influence husband's behavior than the other way around. This may help explain the reason that there is significant health benefit for males in getting married but not for females.

The influence of other persons is particularly strong among adolescents. Researchers found family functioning and perceived peer and parental approval of alcohol use to be important determinants of drinking behavior among teenagers. Adolescents who reported high parental approval of alcohol use also reported high levels of alcohol use by their friends. In a study of health care practices during the first three years of college, both parents and peers were found to have a significant influence on students' alcohol consumption, diet, exercise, and seat-belt use. The researchers concluded that the direct modeling of behavior was the most important avenue of influence by both parents and peers.