# THEORETICAL PERSPECTIVES FOR BEING ADEPT

*Theoretical Perspectives for Being Adept*

*Books:*

***Health Behavior and Health Education: Theory, Research, and Practice (Ed. 4)*** *edited by Karen Glanz, Barbara K. Rimer, K. Viswanath*

> **This seems to be the key reference books cited in this field (over 1400 cites on google docs). Very limited sections available on google reader – for writing grants would certainly want to check out at the library and cite.*

***The Handbook of Health Behavior Change (Ed. 3)*** *Shumaker, S.A., Ockene, J.K., & Riekert, K.A*

> *This is a newer reference book with fewer cites, but still useful for explaining health behavior theories in a high level of detail. The content is more about behavior change than prevention, but some useful stuff on middle school populations in ch 25: Health Interventions for the Young.*

- *Children benefit from interventions designed specifically for their level of development. Children in the middle age group...*
    - *"Are at a concrete-thinking stage of cognitive development and benefit from direct information and practice in performing healthy behaviors" (O'Brien & Bush, 1997)*
    - *Are ready for more creative activities (compared to younger kids who are not ready and older kids who may not be interested) like multimedia games and activities requiring physical movement*
    - *Including parents often leads to more long-term success because they are still in control of many of the youth's activities and still a key role model*

*Articles attached:*

1. *Social Learning Theory and the Health Belief Model by Rosenstock, Stretcher and Becker*
   **Seminal paper on health behavior theory, heavily cited*
2. *Focus Group Interview: An Underutilized Research Technique for Improving Theory and Practice in Health Education by Basch*
   **Heavily cited, argues for the importance of focus groups for improving health education programs – great citation for talking about the uniqueness of how BA is developed. Also gives an outline on how to do FG with this purpose in mind.*
3. *A method in search of a theory: peer education and health promotion by Turner and Shepard*
   **Outlines theories that support the idea peer educators are effective but also argues that there is not a strong body of evidence that this is the effective way to do health education – somewhat outdated article, but shows what I was saying in our meeting that the jury is still out on this in many ways*
4. *Health Promotion by Social Cognitive Means by Bandura*
   **Seminal paper on health behavior theory, mostly focused on social cognitive theory but compares/contrasts with other key health behavior theories*

***There is a chapter (2) in the Handbook of Community Psychology by Marc Zimmerman on Empowerment Theory. This may be relevant for talking about why including youth voice in the development of the program may strengthen the program – but I only have in hard copy. Can access through Emily or me if/when that argument needs to be made for grants*

*<u>Background on Approach:</u>*
*Being Adept focuses on intrapersonal factors –characteristics of individuals that effect their behavior such as knowledge, attitudes, beliefs, etc – and to some extent interpersonal factors – beliefs and actions of important others in student's lives, or in this case (1) their peers in the school and (2) parents.*

*Here I focused here on theories that apply to these factors. Other theories in this literature talk more about factors that influence behavior from the institutional or community level – not as relevant for BA and so not summarized/included.*

| *Theory* | *Author/Citations* | *Determinants of whether or not someone engages in a behavior*<br><br>*i.e. these are the places/perceptions/expectations to target to say that this theory guided or informed the program* |
|---|---|---|
| *Social Cognitive Theory*<br><br>**Interpersonal* | *Bandura (4)*<br><br>*Also discussed in (1)* | *Emphasizes that behavior is determined by continuous feedback between individual and their environment*<br><br>• *What the individual expects will lead to & result from behavior*<br>• *What he believes about his ability to do/not do the behavior*<br>• *The perceived consequences (+ and -) of the behavior*<br><br>*Unique additions of the theory:*<br>• *Emphasizes that people receive information about what to expect after engaging or not engaging in a behavior from multiple sources*<br>• *Distinguishes between expectations about what will happen if you do/don't engage in a behavior (outcomes) and the belief that you can do what is necessary to reach those outcomes (self-efficacy)*<br><br>*Also sometimes called "social learning theory"* |
| *Health Belief Model*<br><br>**Intrapersonal* | *Summarized in (1)* | *Focuses on perceptions: Perceived susceptibility, perceived severity, perceived benefits and perceived barriers:*<br><br>• *Strong enough motivation or concern to make the issues around the behavior feel relevant*<br>• *Belief that you are vulnerable to the supposed consequences of engaging in a behavior (perceived threat)*<br>• *Belief that the outcome of doing/not doing the behavior will be beneficial enough to justify the costs (both financial and otherwise – for example with MS, the "embarrassment" of saying no to drinking at their friends house)* |
| *Stages of Change Theory* | | **This applies more to how health behavior is changed rather than how education can support in prevention. For example, more applicable to smoking cessation than to smoking* |

| | | prevention. |
|---|---|---|

*<u>How to influence self-efficacy (according to Bandura and summarized in article 1):</u>*

1. *Performance or personal mastery/experience doing the behavior: the most influential source – once someone does something over and over, they believe they can do it – idea here is practice, practice, practice doing something*
2. *"Vicarious experience" or watching others do something: also influential, not as much as #1*
3. *Verbal persuasion: this is where most health behavior programs focus – although it can help, #1 and #2 are more influential!*
4. *Physiological states (for example, anxiety): this can help a person decide if they feel capable of doing something like saying no to alcohol, but it's harder to target in health education*
    - *Unless, for example, you talk about what anxiety is, feels like, and how to deal with it – which may help the youth <u>deal</u> with these states, although not necessarily avoid them*

***If we can see ways we try to influence self-efficacy through each of these processes that would be a strong theoretical argument for why you think BA is going to work*

*<u>Peer Leaders (article 3)</u>*

*Key components for modeling to be successful (based on theories below):*
**Note: as I said the other day, there is no general consensus on who makes a good peer leader – here are some ideas from the literature*

- *Someone who is a **credible** source and models the **positive** behavior*
- *Someone who has **high status** with the students – For Jennifer: given the population, who may this be? Local students? Any college students? Also a question to include in the focus groups*
- *Provides **on-going reinforcement** (i.e. don't just mention or show a behavior once –this is the idea that you choose peer models who participants will actually see saying no in the real world – this one may not be possible/relevant for BA)*

*Possible theoretical supports for grants around using peer leaders*
*(From article 3 – I only included promising ones here, and even then they are holes in the theory):*

- *<u>Social Learning Theory</u> talks about how important modeling is to shaping behaviors. Under this context it can be an argument for using peer leaders*

- *<u>Role Theory</u> is based on the idea that there are social roles that are important in influencing behavior – that peer educators may (1) make the information more relevant and (2) be more convincing because they share a more similar set of experiences and culture with the students than teachers do*

- *Communication of Innovations Theory thinks about how new innovations get picked up by groups of people and applies that to behaviors. It argues the pattern of adoption starts with one group of people who take it up immediately, and then there are 'early adopters', the 'early majority', the 'late majority' and finally the 'laggards', including those who never adopt the innovation. This can be applied to behaviors in that you target opinion leaders, or early adopters, as your messengers to other students – emphasizes tapping into existing social communication systems.*
    - *Can also look at the similar diffusions of innovations theory*