A STUDY

OF INDIVIDUAL HEALTH BELIEFS AND PRACTICES

IN RELATION TO PROPENSITY FOR SELFCARE

A Thesis

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Elizabeth A. Nevatt
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A psychology of entitlement

During the past 10 years, our citizens have adopted an attitude which leading opinion pollsters describe as the "psychology of entitlement". Entitlement, in their terms, has replaced expectation. People used to say, "I expect to be healthy five years from now. I expect to be making $2000 more a year from now. I expect to be taken care of in my old age." The attitude now is: "I am entitled to good health. I am entitled to more reward for what I do. I'm entitled to a salary that adjusts with the cost of living. Someone else is responsible for taking care of me when I am old." This difference in attitude may seem subtle but its influence is wide-ranging.

People now expect more from social institutions. They've put higher standards on their institutions, and at the same time they have shifted responsibilities from the individual to the institution. This is particularly true in the health care field. Instead of saying, "I should take care of my health," people are now saying, "They should take care of my health."

The emerging issues are what the researchers call "me issues".

A B S T R A C T

In this thesis the concepts of Selfcare and of health, which is the goal of selfcare, are explored in relation to the selfcare nursing model. It is a basic premise of the selfcare model that the client be involved to the fullest possible extent in regaining or developing selfcare skills. The proposition offered in this thesis is that individuals differ with respect to their readiness for such involvement and effort in their own health work, and hence in ability to benefit from the application of the model. The study aimed at developing a means of identifying and predicting these differences.

It was hypothesized that the individual's perceptions and beliefs about health (Health Concept), his attributions about the location of blame for illness (Blame for illness), and the extent to which he perceives himself as having control over the contingencies of his behaviour (Locus of Control) would all systematically influence his readiness to engage in selfcare (Propensity for Selfcare).

A Health Questionnaire designed to obtain data on individual health related beliefs and practices was constructed. This was mailed to a randomly drawn sample of non-academic staff from one university. A combination of univariate and multivariate analyses of the 86 completed questionnaires showed the major variables as described above to be significantly interrelated. The pattern of relationships which emerged between responses to other items in the questionnaire cast further light on the complex determinants of health behaviour. Of particular interest was the suggestion that the manner of perceiving health is a crucial factor.

Use of the principal axes method of factor analysis allowed a shortened version of the original questionnaire to be produced. The profile yielded by scores on this instrument not only describes the client in terms of the four major health related variables identified in the study but can also be used to predict readiness to benefit from a selfcare nursing approach.

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INTRODUCTION AND OVERVIEW

Over the past twenty years a social revolution in personal health care has taken place. This revolution is evident in the social selfcare movement which has as its ethos personal responsibility in health care. The aim of this movement is personal autonomy and the means by which health is secured is personal effort. The three primary components of the social selfcare movement are universal selfcare, involvement in personal and community health-related decision making, and health deviation selfcare. In selfcare the care of the self may be administered either personally or by others, for example by family, friends, or by health professionals such as nurses.

In Orem's (1971) selfcare model for nursing practice the nurse shares in the client's selfcare responsibility and involves the client in health care decision making until such time as the client can resume full responsibility for health on his own behalf. The parameters of the social selfcare model within which the client's selfcare agency can be exercised are broader than those of Orem's nursing selfcare model. In terms of the social selfcare model not only will the client make decisions about personal selfcare but he may also be involved in health-related decision making at the political level. An essential element of social selfcare is that of learning about and/or using resources which can contribute not only to the regaining of health but also to its qualitative and quantitative advancement.

The client may not want to selfcare to the extent that is implicit in either the selfcare nursing model or the social selfcare model, nor may he feel able to cope with demands and expectations which are new to him. This raises the question of the appropriateness and usefulness of the self-care model of nursing for all clients regardless of their perceptions of both sick-role behaviour and of nursing practice. Smith, Buck, Colligan, Kerndt and Sollie (1980) have demonstrated different perceptions of nursing care by the clients and the nurses in a geriatric selfcare situation,

(with the clients having a better concept of selfcare than the nurses). From a nursing perspective it would be useful to find out if there is some way to assess a client's readiness to benefit from the selfcare approach, either for his nursing care or for his personal health work.

Cromwell, Butterfield, Brayfield and Curry (1977) in their discussion on the management of coronary patients suggest that a clinical judgement may be made regarding the client's perception of agency to achieve outcomes. This judgement is made by discussing with the client what it is that he thinks is in control of his life. The person who perceives that he himself has control over life outcomes is described (using Rotter's 1966 terms) as being internal locus of control, or ILC. Such a person will tend to blame himself for failure to achieve goal directed efforts and will tend to take action to achieve a desired goal. On the other hand a person who is external on locus of control (i.e., ELC) perceives life outcomes to be due more to fate or chance than to personal effort. Locus of control can then be an indicator of client readiness to exercise selfcare agency and also a nursing indicator for differential treatment of ILC and ELC clients.

It is proposed that Cromwell et. al.'s suggestion that selfcare agency be assessed by locus of control orientation can be augmented. Locus of control and preventive health behaviour (i.e., selfcare behaviour) have been found to be associated (e.g., Langlie, 1977). Therefore the current selfcare propensity of a particular client could also be an indicator of readiness for a broader selfcare approach to health care. Preventive health behaviour is also associated with the value that a particular person places on his personal health (Wallston, Wallston, Kaplan and Maides, 1975). Furthermore, selfcare practices are influenced by the manner in which the cause of illness is perceived (Stone, 1979). Therefore not only locus of control but also selfcare propensity, perception of health, and the location of attributed blame for illness could be indicators of readiness for a selfcare approach to health care.

If this is found to be so then it should be possible not only to measure the client's readiness for a selfcare nursing approach but also to assess both the extent to which the nurse can involve the client in personal decision making and responsibility, and the speed with which such a (self-care) program should be negotiated and conducted.

The scope of the social selfcare model is maintenance and advancement of health by the individual. The goal of selfcare nursing is the regaining or sustaining of health by the agency of both nurse and client. The problem is how health, which is the goal of selfcare, is perceived by the person and under what conditions that person would be likely to make use of the selfcare orientation in his or her own health work.

In the following chapters the concepts of selfcare and health are outlined and the individual's role as a self-caring health practitioner is discussed. The construction of a questionnaire designed to elicit information relating to health beliefs and practices is described. Data derived from the administration of this questionnaire were used to test hypothesized relationships between selected variables designated as health related. Further analysis of these data yielded additional information regarding the complexity of individual health behaviour.

In the last phase of the study, some modification of the initial questionnaire was undertaken. This resulted in a potentially more powerful instrument for use in the assessment of individual readiness for a selfcare approach to health care. Practical implications associated with the use of this shorter tool are outlined in the concluding section of the thesis.

To sum up, this present study has a fourfold purpose:

(i) To provide a description of individual health beliefs and practices,

(ii) To investigate relationships between these beliefs

and practices and other selected variables,

(iii) To evaluate the proposition that selfcare propensity, one of the major variables, is predictable from scores on the other three major variables (Health concept, Locus of Control and Blame for illness),
and,

(iv) To refine the Health Questionnaire used for data collection in the present study.