## CHAPTER 5

## CONCLUSION

There were two principal foci of this study. The first was to further understand the roles of, and the relationships between, self-efficacy, health threat, cardiac health locus of control, psychological health and psychological distress, in determining self-reported compliance with recommended health behaviour. In particular, the study attempted to investigate the claim made by Rosenstock, Strecher and Becker (1988) for an expanded Health Belief Model incorporating self-efficacy and health locus of control as components.

The second focus was to attempt to identify whether people at risk of not changing their health behaviour following myocardial infarction could be identified, through measurement of their self-efficacy, outcome expectation, health threat beliefs, cardiac health locus of control, psychological health and level of distress, early in rehabilitation. This would enable further counselling to be given to these people in an effort to reduce their 'at risk' behaviour such as smoking and dietary habits, for example.

Other minor, but psychologically interesting, issues investigated in the course of the study were the durability of the variables investigated over the period of the study, the use of the Multidimensional Cardiac Health Locus of Control Scale and the effectiveness of the Thoughts and Real-life Experiences scale (Dua, 1990) as a measure of psychological distress.

Sixty three men from a major metropolitan public hospital who had experienced an uncomplicated myocardial infarction completed all aspects of the study. These men answered questionnaires prior to discharge from hospital, then 3 months and 6 months later, which measured their self-reported health behaviour, self-efficacy, outcome expectation, perceptions of health threat, health value, cardiac health locus of control, psychological health, psychological distress and a number of demographic variables.

Self-reported health behaviour 3 and 6 months later was found to be independent of demographic variables and severity of infarct. Separate analyses were conducted to investigate how Self-efficacy Theory, the Health Belief Model, Health Locus of Control Theory and variables measuring psychological health and distress might individually predict self-reported health behaviour.

A principal components factor analysis with all independent variables was undertaken to determine possible relationships between the various models used in the study. Reliable factors were then subjected to a regression analysis to determine the best predictor of self-reported health behaviour. Finally, a multiple analysis of variance was conducted to determine the stability of independent variables over the 6 month period.

There were three major problems with the study. The first problem was the use of self-report measures which may cast some doubt on the validity of the findings.

The degree to which the findings can be generalised is the second problem. The sample was relatively small and consisted of only men admitted to one major metropolitan public teaching hospital. While an attempt was made to control for social and physical variables, other factors were not measured that might have exerted an influence on the outcome. Socioeconomic status could have been better evaluated as could level of education.

Differences in the level of understanding of the health behaviour information provided in hospital were also not measured so it is hard to know if health behaviour change was affected by knowledge rather than beliefs. Some patients may have been cared for by more zealous nurses and physicians and may have had their knowledge and understanding reinforced. However, given that the information about desirable health behaviour vis a vis cardiac disease was uncomplicated and all received it, and that health value was high, it seems unlikely that these external forces had a major effect. Nonetheless this and the other aspects of this study mentioned above could have been better controlled.

The third problem had to do with the measures of health threat. Although some studies have had success with fairly simple questionnaires, more confidence in the results would have been obtained with a better constructed questionnaire enabling greater sensitivity and reliability.

Within these constraints, the results of the study have a number of implications both theoretically and practically. While the Health Belief Model, locus of control and self-efficacy all stem from similar theoretical bases, this study sheds doubt on an attempt to incorporate them into the same model. Efficacy expectations, self-efficacy in particular, appear to exert a much greater influence on health behaviour irrespective of other variables. Thus, people's sense of their ability to successfully perform certain behaviours is the principal factor in whether or not they will actually attempt them.

As Rosenstock, Strecher and Becker (1988) point out, the failure to include self-efficacy in research investigating the Health Belief Model may account for much of the unexplained variance. It may also explain inconsistencies in the predictive power of some variables of the Health Belief Model. According to Janz and Becker's (1984) review of 10 years of research involving the health Belief Model, the most consistent factors to affect people's health behaviour were barriers to performing the behaviour rather than perceptions of health threat. Low self-efficacy could be perceived as a barrier (Janz and Becker, 1984).

From a practical point of view, the study supports other indicators that compliance with recommended health action following myocardial infarction could be improved. It would appear that simply providing information is not enough. The findings here suggest that people with low efficacy expectation, identified early in rehabilitation, could receive counselling specifically aimed at improving their self-efficacy. Improving self-efficacy should increase the likelihood of behaviour change.

This research could be repeated with a more controlled sample, more direct measures of health behaviour and with a more sensitive health threat measure. Other studies could also be undertaken to further clarify the roles and relationships between these variables in life threatening situations when health behaviour change is a matter of life and death. Many studies investigating self-efficacy, health locus of control and the Health Belief Model have involved behaviour change when the threat of serious effects is somewhat remote. A controlled intervention study, investigating the effect of changing self-efficacy, health threat and cardiac health locus of control is indicated. Further research with the Thoughts and Real-life Experiences scale also appears warranted with clinical populations.

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