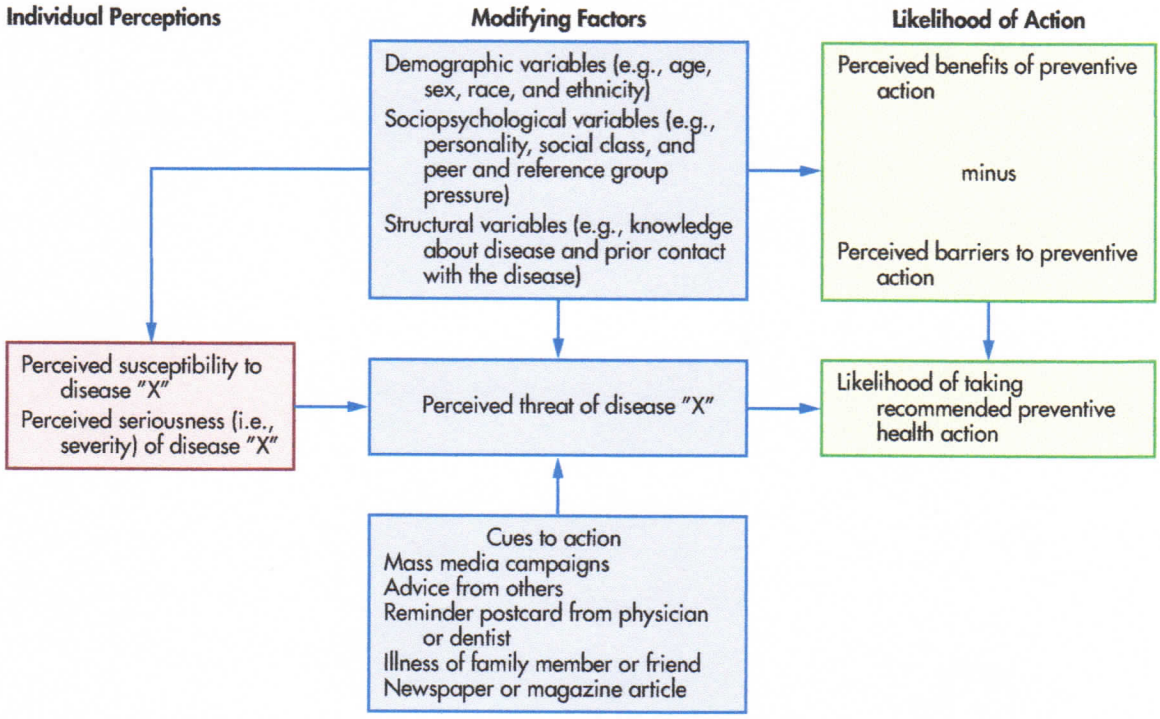

FIGURE 3-1 Variables and relationships in the HBM. (Redrawn from Rosenstock IM: Historical origins of the health belief model. In Becker MH, editor: *The health belief model and personal health behavior,* Thorofare, NJ, 1974, Charles B Slack).

relationships in the HBM. The health belief model is based on the assumption that the major determinant of preventive health behavior is disease avoidance. The concept of disease avoidance includes perceived susceptibility to disease "X," perceived seriousness of disease "X," modifying factors, cues to action, perceived benefits minus perceived barriers to preventive health action, perceived threat of disease "X," and the likelihood of taking a recommended health action. Disease "X" represents a particular disorder that a health action may prevent. It is important to note that actions that relate to breast cancer will be different from those relating to measles. For example, in breast cancer, a cue to action may involve a public service advertisement encouraging women to make an appointment for a mammogram. However, for measles, a cue to action may be news of a measles outbreak in a neighboring town.

Application of the HBM. Over the years, a number of authors have proposed broadening the scope of the HBM to address health promotion and illness behaviors (Kirscht, 1974; Pender, 1987) and to merge its concepts with other theories that describe health behavior (Cummings, Becker, and Malie, 1980). The following section contains a brief personal account of the author's perceptions addressing the strengths and limitations of the model.

During my nursing education classes at the undergraduate level, I was exposed to a large number of nursing theories. The HBM was probably my least favorite. Most of the content was interesting, but I found it difficult applying the concepts to patients in the community and home setting. The model's focus on compliance was something that nurses with a critical theoretical perspective would have difficulty applying in their own clinical practice. My perception of the model changed a few years ago when my younger brother had pancreatic cancer diagnosed. This experience allowed me to see how the HBM could offer some insight into an individual's health behaviors. It helped me organize ideas about why people choose to accept or reject the instructions of well-intended nurses and doctors. Concepts such as perceived seriousness, perceived susceptibility, and cue to action afforded new insights into the dynamics of health decision making. I began to apply the model's concepts to guide my work with my family. My brother who became ill had smoked much of his life. Another brother also smoked. My family members believed that you are destined to follow a path of life and death, but this experience clearly modified their health beliefs. Until this point, my family members did not quit smoking because they did not perceive the susceptibility and seriousness of smoking; they belonged to a reference group that disdained most traditional medical practices and favored inaction over action. During the next several weeks, my siblings requested information on strategies that would help them quit smoking and hopefully decrease their chances for the development of cancer.

Over the years, I have become more skilled in assessing and identifying patient needs and issues and have gained a better appreciation for the strengths and limitations that any theoretical framework imposes on a situation.