Religion and the Health Belief Model

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ABSTRACT: This paper reviews the Health Belief Model (HBM) and the Religious Problem-Solving Coping Scale (RPSC) in an attempt to clarify religion's possible roles in health care actions. The HBM has been used for many years to suggest various influences on health care, including religion. The RPSC Scale investigates religion by looking at characteristics that link religion to the everyday practice of problem solving. Measuring religious beliefs with problem-solving coping allows the influence of religion to be considered in all areas of the HBM. This paper also illustrates the impact of using the RPSC scale and the HBM with implications for ministers and suggestions for further study.

Religious beliefs can influence health care attitudes and behaviors. For example, some religions dictate dietary laws and hygiene practices. However, most research, involving variables such as religious affiliation and church attendance, has failed to find significant relationships between religious factors and health behavior. The absence of significant relationships may be related to the use of measures of religiosity that exclude personal religious beliefs. One such religious belief is the perception of God's role in problem-solving coping. This paper describes the Health Belief Model (HBM) and the development of the Religious Problem-Solving Coping Scale; it also delineates implications for ministers, and suggests further avenues for study.

The health belief model

Rosenstock developed the HBM in the 1950's to suggest reasons individuals were not taking advantage of the medical advances of the time. The model arose out of the medical community's concern about the continued polio epidemics after the Salk vaccine became available. The HBM attempts to identify factors that influence patients' choices in health care matters. The HBM is divided into three categories: individual perceptions, the likelihood of action, and modifying factors.

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Individual perceptions describe the patients' perceptions of the seriousness of a disease and their susceptibility to it. Studies have found that perceived seriousness has a curvilinear relationship to health care action.\(^6\) If the health threat is perceived at either end of a continuum—mild or very serious—individuals are not likely to participate in health care procedures. Perceived susceptibility, on the other hand, describes the patient's belief that he or she may become ill. Studies indicate that perceived susceptibility is positively correlated with health care compliance.\(^7\)

Likelihood of action is determined by the perceived barriers and benefits of a health care practice. When a person is prepared to take action on a health care problem or potential problem, studies indicate that the barriers and benefits will influence the decision.\(^8\) They are often seen as opposing one another. Perceived barriers include cost, inaccessibility of health care resources, and discomfort involved in a health care treatment. Perceived benefits include potential effectiveness and safety of a treatment.

Modifying factor(s) describes the portion of the HBM that includes individual characteristics and experiences that have an impact on an individual’s health care choices. This category is made up of characteristics that are not directly related to perceptions of illness or health care provision. Pertinent demographic information, socio-psychologic variables, and cues to act on health issues, such as advertising campaigns, fall into this category. Age, education, family health beliefs, and contact with a disease are specific factors that influence an individual’s health care choices. Researchers have pointed out that at times the modifying factors overlap. Religious activities and beliefs, which are usually placed in this category, could also be seen as an overlapping variable.\(^9\) With the introduction of the Religious Problem-Solving Coping scale, religion’s influence is no longer limited to the category of modifying factors.

Religious Problem-Solving Coping Scale

The 36-item Religious Problem-Solving Coping (RPSC) scale was developed to investigate the impact of religious beliefs on problem solving.\(^10\) The developers of the scale related problem solving with a person’s ability to cope with life situations. In addition, religion was viewed as an important part of understanding life events, decision making, and maintaining emotional equilibrium.

Items in the RPSC scale reflect six steps in problem solving: 1) defining the problem, 2) developing possible approaches, 3) choosing an approach, 4) implementing that approach, and 5) redefining the problem after resolution while 6) maintaining one’s self emotionally. Moreover, three styles of reli-