The article I chose uses the Health Belief Model (HBM) to determine factors that influence someone from seeking a cognitive status examine. I chose this article because I wanted to expand off of what I talked about in my week 1 discussion related to Alzheimer's Disease. I wanted to look at what makes people decide to receive evaluation for memory problems or what may make them hesitant in wanting to seek evaluation. While no treatment exists to cure Alzheimer's disease, early detection can delay the progression of the disease (Werner, 2003). This study looked at the 5 factors of the HBM, perceived susceptibility, perceived severity, perceived benefits, perceived barriers, and cues to action (Werner, 2003). Using these 5 factors, the study aimed to determine what may influence someone to seek a cognitive status examine.

The study, which took place in Israel, used a convenience sample to interview 186 participants (Werner, 2003). Half of the participants were male and half were female, with a mean age of 64 years (Werner, 2003). 72% of the participants were Jewish while 28% were Arab (Werner, 2003). 73% were married while 27% were not married (Werner, 2003). 42% of the participants had a monthly income of between 4,000 and 7,000 NIS (equivalent to $1130-$1978) (Werner, 2003).

The HBM explains that behavior will occur only when sufficient benefits remain after subtracting the costs incurred by performing the behavior (Crosby, DiClemente, & Salazar, 2013). This study, conducted by Werner, incorporated the HBM in interviews with participants to determine their intentions to seek a cognitive status exam in the presence of memory problems (2003). As mentioned previously, the study uses the 5 factors of the HBM in interviews with the participants to make this determination. Participants were given a 5 point scale to agree or disagree with statements that fell under each of the 5 categories (Werner, 2003). One example used in the study was, "Having a cognitive assessment will allow me to make plans for the future" (Werner, 2003). The findings of the study indicated that the participants showed a moderate to strong indication to seek a cognitive status exam (Werner, 2003). The two factors that were most influential in participants seeking a cognitive status exam were perceived barriers and cues to action (Werner, 2003). These findings did not surprise me. A lot of times, with Alzheimer's disease, family plays a big role in a person's cue to action. The family may be the first to notice signs of the disease and may encourage the person to seek an examination. This social influence plays an important role in cues to action.

One non-significant finding in this study that I found interesting was that higher level of education was only marginally associated with higher intentions to seek a cognitive status exam (Werner, 2003). This finding surprised me. My assumption would be that higher levels of education would significantly affect a person's willingness to seek a cognitive status exam. A higher level of education gives people a background to which they can make informed decisions; however, without a health care background these people may not realize the importance of seeking a cognitive status exam.

Werner suggests that education and counseling interventions should be developed for Alzheimer's disease (2003). Werner also suggests that information and education should be disseminated through mass media and health care professionals (2003). I agree that mass education is important on this topic. It is hard to put myself in someone else's shoes but I can understand why people may be hesitant in seeking a cognitive status exam related to Alzheimer's disease. They may believe that their memory loss is a normal part of aging or they are scared to believe that they may have a disease. The only way we can solve this is through education. As Werner suggests, mass media education is important in order to reach the broadest range of people possible. It is also important to educate family members because these family members play a major role in a person's cues to action, as this study determined.

References

Crosby, R. A., DiClemente, R. J., Salazar, L. F. (2013). *Health behavior theory for public health: principles, foundations, and applications.*Burlington, MA: Jones & Bartlett Learning.

Werner, P. (2003). Factors influencing intentions to seek a cognitive status examination: a study based on the Health Belief Mode. *International Journal of Geriatric Psychiatry, 18*(9), 787-794. doi:10.1002/gps.921

Hi Ben –

Thank you for your discussion post, Alzheimer’s disease is something that many people can personally relate to as it effects so much of the population. As well, you did a great job of explaining the HBM theory to make it easily understandable and applicable to what you were speaking about.

The non-significant finding of higher education that surprised you in not being an indicator to seek a cognitive exam does seem surprising. I do agree with your point that regardless of education level, if it is not in the healthcare field they may be ignorant to the benefit of this testing. I do also wonder though, if maybe this is due to this population having more of an idea of what an Alzheimer’s diagnosis would entail and knowing there is no cure, it may be more of an avoidance measure and wanting to not acknowledge it. I also wonder if this study being conducted in Israel has any cultural skew, and whether conducting it in the United States or a different country if the results would be considerably different.

Regardless of this, I do agree with you that education is the most important intervention available to help overcome the current barriers and move more people into the point where there perceived benefits outbid the perceived barriers and make the cue to action a positive one.

I enjoyed reading your post and thoughts on the subject.

References:

Werner, P. (2003). Factors influencing intentions to seek a cognitive status examination: a study based on the Health Belief Mode. *International Journal of Geriatric Psychiatry, 18*(9), 787-794. doi:10.1002/gps.921