

ABSTRACT

Most current health behavior change models, e.g. the Health Action Process Approach (HAPA) (Schwarzer, 1992; 2004) implicitly assume a high degree of universality. Specifically, it is presumed that health behavior can be predicted on the basis of social-cognitive variables regardless of the participants' social-cultural background, behavior type, or age. However, so far health behavior change models were mostly tested with Western samples, raising the question of whether these models are also predictive in Eastern societies. Thus, the first goal of the present dissertation was to test the applicability of the HAPA-model in an Eastern culture (South Korea) that has morbidity and mortality patterns comparable to Western countries.

Another factor that might limit the universality of behavior change models such as the HAPA is the type of behavior examined e.g., health promoting versus addictive behaviors. Although meta-analyses have shown that the type of behavior influences the degree of intention-behavior consistency (Godin & Kok, 1996; Randall & Wolff, 1994; Webb & Sheeran, 2006). Most of the health behavior change models do not make a difference with regard to the quality of prediction for different behaviors. Thus, the second objective of the present study was to test the applicability of the HAPA to different behavior types.

Another important factor that might limit the universality of behavior change models regards differences in participants' age. From a life span perspective there are age-related changes in life goals (Hooker & Kaus, 1994; Nurmi, 1992) and the motivation to pursue these goals (Freund & Baltes, 2000; Freund & Ebner, 2005; Heckhausen, 1999). Thus, the third objective of this dissertation was to investigate the moderating role of chronological age in predicting the motivation to adopt health behaviors.

Younger (16-35 years old) and older (36-90 years old) adults from South-Korea ($N = 697$) participated in a longitudinal health screening study with a 6-month interval between assessments. Participants filled out questionnaires assessing different health behaviors (nutrition, physical activity, smoking, and alcohol consumption) and domain-specific social-cognitive variables such as risk perception, outcome expectancies, perceived self-efficacy, intention, and planning.

In general, the HAPA-Model had a good fit across different health behaviors pointing to the applicability of the HAPA to a non-Western culture. However, more variance could be explained in health promoting behaviors, such as nutrition and physical activity, in comparison to health impairing behaviors such as alcohol and cigarette consumption. For all health behaviors, with the exception of smoking, where age comparisons were not possible, age differences were found in the motivational processes and not in the volitional ones. The perception of one's own vulnerability for cardiovascular diseases motivated older adults but not the younger ones to adopt a healthier life style. The acknowledgment of the positive consequences of physical activity and a limited consumption of alcohol for ones health fostered intention formation in the group of older adults but not in the younger ones. A reason for the observed differential effects of age could be that nutrition, physical activity, or reduction of alcohol consumption are regarded as explicit health behaviors by the older group, whereas they are considered as lifestyle factors by the younger ones. However, self-efficacy emerged as the major determinant of reported health behaviors in the older and younger group, indicating that self-regulatory resources are a prerequisite for successful performance regardless of age.

Three conclusions regarding universality of the HAPA-Model can be drawn from the results of the present study. The HAPA model could successfully be applied to a sample with a non-Western cultural background (Korea). But, two limitations regarding the generality of the social-cognitive models, e.g. the HAPA, should be considered. One of them concerns the quality of behavior prediction for different types of behavior. In the present study health promoting behavior, such as nutrition and physical activity, were better predicted by the HAPA-Model than health impairing behavior, such as alcohol and cigarette consumption. The present findings imply that health behavior is not a unitary construct that can be equally well predicted by the same set of variables regardless of behavior type. Another limitation regarding the generality of the HAPA-model concerns its applicability to different age groups and constitutes the third conclusion from the present study. Considering the insights from life-span psychology, it seems reasonable to adjust current health behavior models to the uniqueness of different age groups. Middle-aged/ older adults might be strongly driven by a health-preventive goal orientation, aiming at maintaining health and decreasing health risks, as compared to younger adults. Therefore, health

behavior change models targeting behaviors that are viewed as health-related only by people of certain age might be particularly applicable to this age group.