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Weight control specific compensatory health beliefs: Hypothetical testing and model extension

Sittichai Thongworn*, Veena Sirisuk

Department of Society and Health, Faculty of Social Sciences and Humanities, Mahidol University, Nakhon Pathom 73170, Thailand

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ABSTRACT

Compensatory health beliefs (CHBs) refers to the beliefs that unhealthy behavior can be compensated for by activating healthy behavior. The purposes of this study were to investigate various theoretical hypotheses in the CHB model and to present a model whose concept expands from the original CHB model. A cross-sectional survey was designed for the present study. The sample consisted of 788 undergraduate students (mean age 19 years). All participants were asked to complete a questionnaire regarding weight control specific CHBs, self-efficacy, self-concordance, motivational conflict responses, compensatory behavior intentions, and actual behavioral control. Path modeling showed that the degree of desirability influenced resolving motivational conflict by resisting desire and adapting risk perception/outcome expectancy when implementing tempting behavior. Identified self-concordance had an influence on resolving conflict by resisting desire. Weight control self-efficacy had an influence on resolving motivational conflict by resisting desire and adapting risk perception/outcome expectancy when implementing tempting behavior. Weight control self-efficacy had an influence on identified self-concordance. Compensatory behavior self-efficacy had an influence on compensatory behavior intention. Actual behavioral control had an influence on compensatory behavior intention and compensatory behavioral self-efficacy. Further work is required to explore all of the processes of the model.

Introduction

A study on the prevalence of weight control and weight loss among Caribbean adolescents revealed that the weight control prevalence between male and female adolescents was different; that is, female adolescents were more likely to control their weight than their male counterparts. In addition, 40.5 percent of female adolescents and 25.2 of male adolescents wanted to lose their weight through dietary control and exercise (McGuire et al., 2002). In Thailand, the reviewed literature shows that there have been studies on weight control prevalence among Thai adolescents, but all of them were conducted on small sample groups. Based on the studies, 38.2 percent of the samples controlled and lost their weight (Tinkajee & Pumwiset, 2016), and 43.1 percent used to lose weight (Choundchumnum et al., 2005, pp. 1–9). The data on weight control among Thai adolescents manifests that the level of Thai adolescents' weight control is quite high and similar to adolescents in foreign countries.

Some studies showed that within five years, individuals who tried to lose or control their weight usually gained back the weight they had lost, and in another five years, the weight they gained back was greater than that they had lost. Similarly, those who had just started exercising always

* Corresponding author.
E-mail address: sittichai_psycho@hotmail.com (S. Thongworn).
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gave up exercising within the first six months (National Task Force on the Prevention and Treatment of Obesity, 1993). In addition, although individuals had knowledge about behavior that had negative health impacts, for example, consumption of excessive food or a lack of exercise, and tried to have a lifestyle was healthy, their efforts were not successful (Pinel, Assanand, & Lehman, 2000).

Academics have attempted to understand the factors which contribute to low levels of commitment to self-set health goals. Part of the psychological explanation for this phenomenon focuses on reasoned cognitive processes (Ajzen, 1991; Rogers, 1985). One cognitive process that impacts an individual's decision to indulge is the activation of compensatory beliefs (Rabiau, Knäuper, & Miquelon, 2006). Compensatory health beliefs refer to the idea that the negative, but often desirable, consequences of unhealthy behavior can be compensated for by engaging in other behaviors that have good health impacts (Rabiau et al., 2006).

Rabiau et al. (2006) proposed that a reasoned cognitive process is undertaken when there is a motivational conflict or an incompatibility between the temptation to engage in unhealthy behavior and self-set health goals. This incompatibility creates three motivational strategies to resolve the conflict: 1) resist the desire, 2) adapt one's risk perception/outcome expectancy, and 3) activate compensatory health beliefs (Rabiau et al., 2006). They also proposed that the degree to which the behavior one is tempted to engage in is desirable influences the activation of compensatory health beliefs. Moreover, Rabiau et al. (2006) suggested that when the temptation is to engage in a behavior that is undesirable, individuals should be able to resist the desire and not need to rely on or activate compensatory health beliefs. In addition, when faced with the temptation to engage in a behavior that is exceedingly desirable and essentially irresistible, they would not be able to activate Compensatory Health Beliefs (CHBs) because they believe that the intensity of the temptation and the desirability of the behavior justifies self-indulgence. CHBs tend to be used when the desirability degree is at a moderate level (Rabiau et al., 2006). Furthermore, self-efficacy was considered as another factor that influences CHB usage. Rabiau et al. (2006) suggested that high self-efficacy is associated with the levels of implementing CHBs. That is, individuals with high self-efficacy should experience a low tendency to activate CHBs. The value of individuals' self-set goals is another factor that may affect the levels of motivational conflict (Rabiau et al., 2006). Goals such as exercising regularly, eating a healthy diet, and quitting smoking can be achieved through self-set motivation. Highly self-motivated people are very interested in attaining their goals or set goals with which they have concordance and great determination to succeed. In addition to utilizing self-motivation to attain goals, individuals may be externally motivated to succeed. The potential for external reward or punishment may cause guilt or anxiety, or conflict between themselves and their goals. Therefore, health goal self-concordance should be another variable that influences behavior in people responding to their internal conflict (Rabiau et al., 2006) as shown in Figure 1.

Despite the fact that there is significant amount of empirical evidence confirming that compensatory health beliefs affect self-regulation, especially in terms of individuals' health behavior (Kronick & Knäuper, 2010; Miquelon, Knäuper, & Vallerand, 2012; Monson, Knäuper, & Kronick, 2008; Nguyen, Knäuper, & Rabiau, 2006; Rabiau, Knäuper, Nguyen, Sufrategui, & Polychronakos, 2009; Radtke, Scholz, Keller, Knäuper, & Hornung, 2011), there are some questions that have not yet been studied. There is little empirical evidence to support the hypotheses about determinants of conflict resolution strategies when encountering conflict between health goals and desires, as presented in the CHB model (Rabiau et al., 2006). These reasons have led to this study.

Research Objectives

The present study aimed to investigate various theoretical hypotheses presented in the compensatory health beliefs model by Rabiau et al. (2006) and to present a model whose concept expands from the original compensatory health beliefs model.

Method

Participants

The study was conducted using a community sample of undergraduate students from a single university in northern Thailand (N = 788). A multi-stage sampling strategy

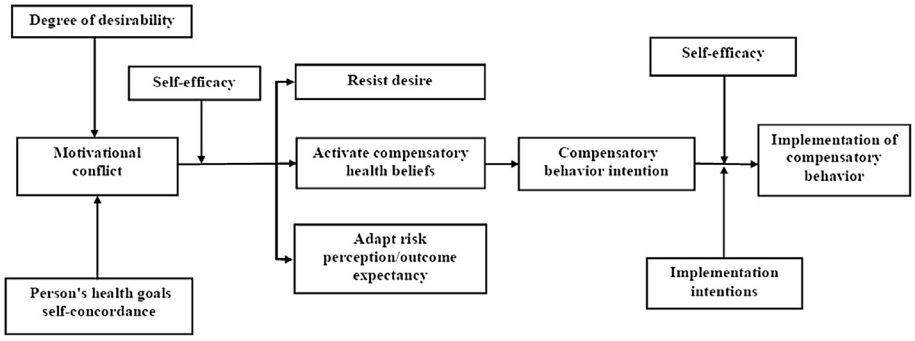

Figure 1 Compensatory health beliefs model
Source: Rabiau et al. (2006)

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