Changing Health Behavior in Youth

Godfrey M. Hochbaum

This paper is reformatted and reprinted as part of the 40th anniversary of the American Journal of Health Education *(formerly* School Health Review) Health Education – Our Heritage series. *The original paper appeared in Volume 1 (September 1969, pp. 15-19). At that time, Godfrey M. Hochbaum was deputy director, Social Analysis and Evaluation Program, National Center for Health Services Research and Development, Health Services and Mental Administration, U. S. Public Health Services, Washington, D.C.*

Before considering the need for changing health behavior, it may be useful to think about how we learn health behavior to begin with. This should help us to understand the reasons why it is often difficult to effect changes – and how we may succeed.

From the moment the infant is born, almost everything done for him is intended to protect him against harm and to promote his physical and mental development. The infant is helpless and vulnerable, and his health and safety depend entirely on what adults can do for him.

As he grows older, some of the responsibility for his own health, safety and welfare is gradually shifted to him. He is led to acquire certain health habits, such as keeping his body clean, not to play in the street, and so on. He begins to learn that if he does certain things they will cause pain either directly, as when he burns himself on a hot object, or through punishment from his parents, as when he is spanked for playing with matches. On the other hand, he reaps rewards for "good" behavior. He feels better when a wound is cleansed and dressed, or he is praised after brushing his teeth. Through such rewards and punishments, he learns to differentiate between desirable and undesirable behavior and acquires various habits and behavior patterns, even though at this young age he does not yet know and understand their implications for his health.

Which behaviors he learns to consider desirable depends, of course, on what his parents and other adults around him happen to know and believe – and this may not always be correct. But there are also other sources – the child has varied experiences with illness and with medical personnel, both of which influence his feeling and thinking about health. Perhaps even more important are the many bits and pieces he picks up from overhearing adult conversations, from the often distorted and misinformed stories he hears from other boys and girls, from watching TV programs and commercials, etc.

Out of all these diverse, often unreliable, and unrelated sources of health information, he forms ideas, attitudes and beliefs about health and illness before he is able to sort out the valid from the erroneous, and the reliable from the unreliable, and before he understands *why* some of the practices which he acquires are more important for his present and future health.

As he grows older, and especially once he goes to school, he is exposed to more systematic and reliable health information. He also becomes more capable of judging and deciding for himself. It may happen that what he now learns fits in well and reinforces already existing beliefs, attitudes and habits. Thus, if he now learns about the beneficial health effects of oral hygiene this may strengthen his long-established oral hygiene habits. It may, however, happen that what he now learns is different from what he has earlier come to think, believe, or do – in which case he has to choose between the new or the older ideas and habits.

The trouble is that many of these early established patterns of behavior and their underlying beliefs and views are by now deeply ingrained and often quite resistant to change, or at least to the complete change that would be suggested by his new knowledge. And so he carries with him both the old and the new, even though these may be fundamentally opposed to one another.

We then see that the school child has health information, attitudes, values and habits which are the product of multitudinous sources, influences and experiences. Since few of these were planned or offered him in any systematic fashion, and since many of these sources are not necessarily well-informed ones, it is no wonder that his knowledge, attitudes and practices are a hodgepodge of correct information and misinformation, of desirable and undesirable attitudes, and of habits – some of which

tend to promote and some of which tend to threaten his health. The problem is that he cannot distinguish between these. And he is rarely, if ever, aware of the fact that he thinks, feels and acts in an astoundingly inconsistent, often paradoxical, manner.

Let us remember that we are not much better, even those of us who are professionally active in the health area. Some of us carefully wipe our hands dry before touching an electric switch, but do not fasten our seatbelts when we drive; some of us go to the dentist religiously every six months, but have not had a medical examination for several years. Some of us feel it is terrible to use marijuana, but enjoy our cocktails or cigarettes; some of us object to cigarette commercials, but cannot tear ourselves away from TV shows that detail how one can commit all sorts of crime.

As we try to teach the child about health matters, we may tell him things which differ from and may even contradict things he has learned before, and may be counter to some of his present health practices. If his attitudes, beliefs and habits were consistent and systematic, he would probably be acutely aware that what he now learns does not fit in and would attempt to understand and resolve the discrepancy. But since his present health habits, beliefs and attitudes are already unsystematic, inconsistent and full of contradictions, the addition of more material that does not fit in is not particularly disturbing to him. In fact, it is the very lack of consistency in his health views that is rather convenient, since it allows him to choose from his store of health knowledge, attitudes and practices those elements which appear to be expedient for one purpose in one situation, and to choose other, possibly contradictory, elements for another situation. This is exactly what adults have learned to do no matter how we flatter ourselves on being rational and conscientious in our health behavior. We, too, tend to bend our health knowledge to our wishes and find some good and plausible reasons to do what we want to do, even when it runs counter to what we know would be the right thing to do.

And so, what we teach the child in school may simply add to his armamentarium of arguments to use when it is expedient or to disregard when it is not. In short, we give him additional health knowledge, but may fail to help him make sound and consistent choices in his health behavior.

This implies that our focus on teaching health knowledge will very often be a futile effort if our aim is really to change behavior. Our focus as health educators must be on the *application* of this knowledge, because this is where the weakness lies. This requires that we deal with two important issues: (1) the guiding principle underlying *all* desirable health behavior, and (2) possible problems and difficulties in applying health knowledge to everyday situations.

A COMMON DENOMINATOR — THE EFFECTS ON HEALTH

The guiding principles underlying all desirable health behavior is best explained through an example. Athletes are taught to follow a number of health practices, such as certain regular exercises, given diets, abstinence from tobacco and alcohol, etc. Through all of these, there runs a common principle: all of them serve one single purpose which is important to *all* athletes – to be optimally fit for the game or athletic contest. It is the athlete's dedication to this purpose that lends common meaning and importance to each of the separate injunctions and ties them together into an integrated and consistent behavior pattern. This is why most athletes usually follow and obey *all* their health rules rather than only when one or the other rule happens to be expedient. The violation of any one of them means, for the athlete, a violation of the principle itself.

But we do not usually approach health behavior in this way with most children, or for that matter, with most adults. We tend to teach that smoking is bad because it causes cancer; that a balanced diet is important to health in general (whatever that may be); that one should see the dentist regularly to prevent cavities.

In other words, each injunction is related to a separate health problem in a totally disjuncted manner. As a consequence, we often create a feeling that health professionals are trying to deprive our youth (as well as adults) of everything that is fun and makes life enjoyable: that for everything people like to do, we have some reason why they should not and, on the other hand, we always find some reason why they should do something they dislike.

Quite possibly some of the bad health effects with which we threaten our children, and some of the good effects which we dangle before their eyes, may not mean much to them. For example, the warning of the risks of cancer after many years of heavy smoking may be too remote to a 15 year-old who smokes only a few cigarettes a day and is convinced both that he will not increase his consumption and that he can stop any time he really wants to do so. The ideal of "good health" from proper nutritional practices may similarly be a meaningless abstract to a healthy youngster.

I believe school health education (and health education in general) must find ways of providing an integrated view of health and health behavior and unifying principles and purposes. I realize that this is easier said than done. I wish I could tell you, but I can't, how to make health itself a meaningful, deeply valued purpose to which our children become and remain devoted. One thing is sure: the task requires enthusiasm and a deep conviction on the part of educators and the gift of being able to inspire children. These qualities are more important than any teaching techniques.

I am also sure that the teacher cannot do it by himself. He must actively involve children themselves in the process. Discussions among them, skillfully guided by the teacher, are probably more effective than any lecturing or reading.

I am strongly convinced that we defeat our purpose by teaching each health subject (such as smoking, excessive use of alcohol, drug addiction, sex education, driving safety, etc.) separately. This is all right when we wish to provide children with the requisite knowledge about the nature, scientific

evidence of hazards, and other substantive aspects of these subjects. But when we wish to influence children to draw logical implications from what they have learned and to apply them to their daily life, we must deal with these subjects within a single framework and in the light of their common denominator – *their effects on health*. The improvement and safeguarding of one's health must be made the single, unifying principle that gives meaning and significance to each separate subject. The wish and the ability to be healthy, to enjoy one's body, the capacity to have control over and use one's body to serve one's larger goals in life, must be instilled in children as deeply felt and aspired-to ideals to which all the separate subjects are only means.

I understand that in physical education something of this is beginning to take hold: to use physical education as a means to motivate children not just to be able to run fast, to throw a ball correctly, or to perform certain feats in the gymnasium, but to teach each child to value and enjoy his body, and to be proud of being able to use and control it to the optimal degree of his own individual capacity.

DIFFICULTY OF APPLICATION OF EVERYDAY LIFE

The second important issue which I have mentioned is that of possible problems and difficulties in applying health knowledge, once acquired, to everyday living. Again, a few examples will help.

We teach our children that they should brush their teeth after every meal. This seems a simple enough thing to do. Yet, the child who tries to do it in the school's restroom after lunch may find himself ridiculed by his schoolmates. Or we may successfully convince a young boy that he should not take up smoking. But, under the constant powerfully persuasive influences of his smoking friends, he may find it impossible to stand up against them.

Unfortunately, it is rare that we try to learn what problems or difficulties various children may have in trying to apply the health knowledge we have given them; and it is equally rare that we devote as much effort to helping them find ways for dealing with these problems as we devote to passing on knowledge and giving them reasons why they should engage in more desirable health practices.

I do not know with how many children we are highly successful in our educational efforts, only to lose them because of this failure on our part.

Recently I happened to get into a discussion of smoking with the adolescent son of an acquaintance. He was not really a smoker although he did smoke a cigarette occasionally. He was defiant about the habit, defending it as enjoyable and helpful in many situations, and he denied being concerned about its possible health effects, about which he was well informed.

It soon became clear to me, however, that he really did not particularly enjoy cigarettes, that he had given quite some thought to the health risks, that he smoked only because all his friends and his girlfriend did, and he felt he would not be completely accepted by them otherwise.

In other words, he probably was ready to relinquish smoking, but, because of the influence of his friends, found it hard to do. So, instead of arguing against smoking and trying to persuade him to quit, I changed the subject and talked about how easy it is to "ape" others, and how much more difficult, rewarding and satisfying it is to be an individual who makes his own decision and refuses to give up his independence just to blindly follow the herd. I happened to know that this boy prided himself on these traits. We agreed that the proof of independence and individuality lies in the ability to be true to oneself and to adhere to one's own convictions rather than take the easy way out and to conform to the behavior of others.

It was only then that I brought the topic back to smoking, drawing the obvious implications. The boy has not touched a cigarette since, and he also persuaded his girlfriend to stop smoking, using the same arguments with her.

The point is that he had the knowledge he needed to change his behavior, but continued to smoke because of his disinclination to run against what was the accepted behavior pattern among people important to him. It was neither lack of knowledge, nor lack of motivation, but the problem of overcoming barriers to change that stood in his way.

This illustrates that we must pay much more attention to how a child can apply his health knowledge and overcome the difficulties he may encounter. When children fail to follow our exhortations, we try to force more knowledge of facts on them and argue with them, when the question is really one of lack of knowledge of how to apply what they already know, or lack of ability to overcome barriers to such application.

When you face a large group of students and it is impossible to devote enough attention to individuals, even then you can apply the same principles to some extent, you are also aware that the group consists of subgroups, each of which has certain things in common, but differs from the other subgroups.

Take, for example, the subject of food habits. Some of your students may come from homes where food is plentiful and the problem is one of overeating or an ill-advised choice of foods. Others may come from extremely poor homes where the problem is one of insufficient nutrition, and where lack of money severely hinders not only any increase in food consumption but a properly balanced diet. It is obvious that these two groups bring to the classroom different experiences, attitudes and capacities to effect dietary changes. Therefore, merely telling them about good and poor nutritional practices will not produce much change in their behavior. Moreover, chances are that such teaching will be meaningless to those whose parents can hardly afford the foods they now serve. It would be necessary to discuss problems of proper nutrition as they apply both to families who can and to families who cannot afford the kinds of changes we would like to see. What are the problems that these two kinds of families face in changing their dietary patterns, and how can they overcome their respective problems? Even more important, what can

the students themselves in the two groups do, and how can they go about it?

I have focused on two issues which, I feel; do not receive enough attention, despite their significance and their important implications for health education.

The first issue is the need to relinquish our emphasis on providing knowledge for knowledge's sake, in the hope that this alone will accomplish our educational goals. Quite apart from the fact that knowledge alone is not enough to give us wisdom in behavior, knowledge by definition is tied to separate- and distinctly-defined subjects. That is why, as a rule, we must deal separately with such subjects as smoking, alcoholism, drug addiction, physical exercise and nutrition, or we talk about the scientific basis of these subjects. But wisdom in one's daily conduct comes only from being guided by an overriding, general principle, purpose, or goal, which must be applicable to a large range of conditions and situations. Therefore, we must make health itself such a principle or purpose, with all health subjects being treated merely as means or tools to serve it. We should watch our diet, be immunized for various diseases, exercise, practice personal hygiene, etc., not just because each has its own benefits, but because all of them, together, serve our health. We must abstain from smoking; excessive drinking, LSD, etc., not just because each has its own special dangers, but because all of them endanger the sanctity, safety and health of our bodies and minds.

Only with this approach can we hope to become more effective in making health knowledge a meaningful tool to be used by our children conscientiously and consistently, rather than merely as tool to pass examinations in health education courses.

Finally, we have to pay more attention to problems of applying health knowledge to various conditions and in different situations. We have to learn from our children what difficulties they may have, or anticipate; in living up to what they know are the right things to do. And then we must find ways of helping them with these problems.