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Section D

Other Models of Decision Making
Health Belief Model (Rosenstock and Becker)

- Perceived *severity* of the condition (HIV)
- Perceived *risk of acquiring* HIV
- Perceived *benefits of taking actions* to prevent acquiring HIV
- *Barriers to taking an action* to prevent acquiring the condition
Theory of Reasoned Action

- Intention to take an action is determined by:
  - Person’s attitude toward the behavior (e.g., beliefs about the outcomes of the behavior and the value of these outcomes)
  - Influence of a person’s social environment or subjective norm (e.g., others’ opinions of what I should do)
Theory of Reasoned Action/Planned Behavior

- Three factors influence whether and to what extent behavioral intent shapes our behavior
  1. **Volitional control**: we must have control over our behavior (often there are other factors outside our control that influence our behavior (e.g., income)
  2. **By looking at behavior you can’t deduce intent**: I may intend to prevent HIV and may have done something that I thought would protect me, but I did something that made no difference because I didn’t really know what to do

Source: Fishbein, Ajzen.
3. Behavioral intent and behavior must be measured at the same time: attitudes change over time, so to look at behavior and attitudes at two different times tells us little. Behavioral intent and attitudes co-vary (as one changes so does the other).

Source: Fishbein, Ajzen.
Gist Theory

- Decisions are not reasoned in a logical stepwise process; rather, people use *gist-based* cognition.
- **Gist-based** or fuzzy reasoning are mental representations quickly made based on getting an overall sense or gist of the situation.
- Adolescents use gist-based reasoning less than adults (Farley and Renya).