Avoiding poor health or approaching good health: Does it matter? Conceptualization, measurement and consequences of health regulatory focus

Abstract: This research describes the development of the Health Regulatory Focus Scale (HRFS), which was designed to capture individual tendency to use avoidance or approach strategies during health goal pursuit. Scale development procedures confirmed the structure of the scale and validated its psychometric properties. We then investigate its relationship with different health outcomes. This health specific measure predicted health beliefs, health behaviors and health subjective state.
The motivational underpinnings of health behavior have been largely ignored in the marketing literature (Briley and Aaker, 2006). The regulatory focus theory (Higgins, 1997) offers a relevant theoretical framework to understand how basic motivations influence health behaviors. In this regard, some researchers have proposed that hoped selves or feared selves could act as motivational incentives (Hooker et Kaus, 1994). However, although regulatory focus theory has already been applied to health message persuasion and health behavior (e.g.: Keller, 2006; Fuglestad, Rothman and Jeffery, 2008), no effort has been made until now to adapt it to the health domain. The present research proposes that individuals could vary in their spontaneous tendency to represent their health in terms of desired state or undesired state and that this individual difference influence their health beliefs and behaviors. Because other variables has been successfully adapted to the health domain (e.g.: Wallston et alii, 1978 ; Schwarzer and Renner, 2000) and because past researches using general measure of regulatory focus has lead to mitigated results (e.g.: Vartanian, Herman, and Polivy 2006), conceptualize health regulatory focus and build a specific tool of measurement seem to be an important step to engage.

Development and validation of the health regulatory focus scale

To generate items our initial set of 50 items for the HRFS, we first closely examined instruments used to measure general regulatory focus and second conducted in-depth discussions with 8 consumers. 31 items were finally selected by four expert judges and administered to a sample of 187 consumers. The factorial analysis with oblimin rotation was used to check the factorial structure of the measure. A two factors solution is obtained and explained 58% of the variance. Moreover, the correlation between the two dimensions is low ($r = .16, p < .001$). The final version of the HRFS includes 8 items (five items for promotion dimension and three for prevention dimension). To assess the relationship between, general regulatory focus and health regulatory focus, the RFQ (Higgins, 2001) has also been administered to the sample: no significant correlation exists between these two constructs. To validate the HRFS, the items were administered to a sample of 1600 consumers. After checking for the items multinormality, we adopted the maximum likelihood and the bootstrap procedures to conduct the analysis. All the indicators have confirmed that the model fits the data well ($\chi^2 = 151.67; GFI = .98$ AGFI = .95, $CFI = .97$, $TLI = .97$, $RMSEA < .08$). The model shows that the correlation between the latent constructs and its items are always over .5, and that the error terms variance is bellow the acceptable threshold of 2.58 (Hu and Bentler 1998). However, the correlation between the two latent constructs is much higher than in study 2 ($r = .79, p < .001$). This result threatens our two dimensions solution. To avoid any doubt about this issue, we conducted a model comparison using the chi-square difference tests recommended by Anderson and Gerbing (1988). The results argue that a two constructs model solution fits the data better. The increase in chi square is 283.37, which is significant at $p < 0.01$. These results support the discriminant validity of the HRFS. Each of the resulting scales exhibits good internal reliability: Cronbach alpha and Joreskog’s Rhô were superior to recommended thresholds.

Nomological studies: consequences of health regulatory focus on health beliefs, health behaviors and subjective health state

Using the data described earlier (n=1600), the goal of the study 2 is to test the ability of the HRFS to predict health beliefs, health behavior and subjective health state. To test our hypothesis, we create an HRF index by subtracting participants’ promotion scores from their prevention scores. We then perform a tertiary split on this index, creating a predominant promotion group and a predominant prevention group (Camacho, Luger and Higgins, 2003).
Concerning health beliefs, based on prior existing research, we expect a relationship between health regulatory focus and health locus of control (Pham and Higgins, 2005) and health risk (Leikas et alii, 2006). Confirming our expectations, the results showed that people with higher prevention score have a stronger external locus of control (doctors and chance). However, no significant relationship is found between internal locus of control and promotion orientation contrary to what we expected. To test the influence of health regulatory focus on health risk assessment, two scenarios manipulating health risk due to a decrease in immune system function were presented to respondents. There was a significant relationship between health risk perception and health regulatory focus. In comparison to promotion oriented respondents, prevention oriented respondents have higher scores of perceived severity and susceptibility. Promotion oriented consumers were also more likely to adopt approach health behaviors (e.g. sport practice, eat 5 fruits and veggies). We have also found that promotion oriented consumers initiate a larger number of health behavior. This result is consisting with the fact that promotion-oriented consumers exhibit a greater need for variety in their self-regulation strategies (Pham and Higgins, 2005). It appears also clearly that promotion-oriented consumer demonstrate greater ability to maintain these health behaviors. It could be explained by the fact that promotion orientation influences positively the motivation to persist on a complex task (Crowe and Higgins, 1997). Finally, consumers who are promotion-oriented have higher score of subjective health state. This result supports the idea that under prevention, consumers are more likely to perceive their current health state as a source of potential problem. Additionally, a significant relationship between promotion orientation and optimism and between prevention orientation and neuroticism provide further evidence of the good validity of the HRFS.

To conclude, health regulatory focus seems to be an important concept to understand consumers’ health motivation and especially how this motivation influence health outcomes. More research is needed to assess the additional contribution of the HRFS versus more domain-general alternative and explore its impact on consumers’ health status and health information processing.

References:
