

Self Rated Abilities for Health Practices Scale (SRAHP)

LIPHIP Wellness Survey is adapted from: Becker, H., Stuijbergen, A., Oh, H., & Hall, S. (1993). Self-rated abilities for health practices: A health self-efficacy measure. *Health Values* 17(5), September/October, 42-50

Description

The Self Rated Abilities for Health Practices Scale (SRAHP) is a 28-item, 5-point scale to measure self-perceived ability to implement health-promoting behaviors. SRAHP contains four subscales: Exercise, Nutrition, Responsible Health Practice, and Psychological Well Being. Each subscale has seven items. Respondents are asked to rate the extent to which they are able to perform health practices related to these four domains. An example of an item from the Health Practices subscale is “I am able to get help from others when I need it.” Items are rated from 0 (not at all) to 4 (completely). Ratings for each subscale are summed to yield subscale scores. Subscale scores are summed to obtain a total score. Total scores range from 0-112. Higher scores indicate greater self-efficacy for health practices.

Scale and Scoring

The following scale asks whether you are able to perform various health practices within the context of your lifestyle and any disabilities you may have. This includes any assistance you have available to you, such as an attendant to help with stretching exercises, for example. Read each statement and use the following scale to indicate how well you are able to do each of the health practices, not how often you actually do it.

4 = Always (continually)

3 = Often (mostly)

2 = Somewhat

1 = Rarely (a little)

0 = *Not at all*

Reliability and Validity Evidence

Psychometric properties of SRAHP were investigated in three samples: persons who attended a city wide health fair (n=188), undergraduate students in a health promotion class (n=111), and members of a statewide advocacy group for persons with disabilities (n=117).

Content Validity. An initial pool of 50 items was generated to assess health-promoting activities in the areas of nutrition, exercise, psychological well-being, and health responsibility. The number of items was reduced to 32 with the assistance of a rehabilitation nurse consultant. A 32-item measure was reviewed by a group of expert reviewers and was pilot tested with 15 adults. Content was modified based on feedback from the expert reviewers and pilot subjects, resulting in a 28-item, 5-point scale that asks respondents to rate how well they are able to perform each health practice.

Sample 1: Health Fair Attendees.

Factor Analysis. Principal component factor analysis with Varimax rotation was performed to examine the factor structure of SRAHP with data from the Health fair attendees sample. A four-factor solution emerged, with each factor accounting for at least 5% of the variance. The items clustered under four factors: exercise, nutrition, psychological well-being, and responsible health practices. The four factors accounted for 61% of the variance. Factor loading for all items was greater than .48. The one exception was the toothbrush item on the Nutrition

subscale, which demonstrated a higher loading on the exercise subscale. Because it does not fit conceptually in the Exercise subscale, it remains in the Nutrition subscale.

Reliability. The health fair attendees ($n = 188$) were 39% men, mean age of 37, 76% Anglo, and 54% married. Most (80%) had attended at least some college, 79% were employed, and 4% were retired. Eighty percent reported no chronic illness or disability. Cronbach's alpha for the health fair attendees was .94 for the total scale, and .92, .81, .90, and .86 for the Exercise, Nutrition, Psychological Well-Being and Responsible Health Practices subscales, respectively.

Validity. Scores on the General Self-Efficacy Scale (Sherer, Maddux, Mercandante et al., 1982) were moderately correlated with total scores on the SRAHP ($r = .43$). General Self-Efficacy Scale scores were most highly correlated with the Responsible Health Practices and Psychological Well-Being subscale of the SRAHP ($r = .44$ and $r = .43$, respectively). All correlations were significant at the $p < .01$ level.

Sample 2: Undergraduate Students.

Test Re-test Reliability. SRAHP was administered twice at an interval of two weeks. The Pearson Correlations between the two administrations were .70, .63, .63, .69, and .73 for the total scale and the Nutrition, Psychological Well-Being, Exercise, and Responsible Health Practices subscales, respectively. Cronbach's alpha for the total scale was .94, and .81, .86, .89, and .88 for the Nutrition, Psychological Well-Being, Exercise, and Responsible Health Practices subscales, respectively.

Validity. The undergraduate students enrolled in a health promotion class completed the SRAHP, the Health-promoting Lifestyle Profile (Walker, Sechrist, & Pender, 1987), and the Barriers to Health Promoting Behaviors Among Persons with Disabilities Scale (Becker, Stuifbergen, & Sands, 1991). Table 2 shows Pearson correlations between the measures.

Sample 3: Adults with Disabilities. To examine if the Self-Rated Abilities Scale could distinguish between persons with and without disabilities, scores of the health fair attendees were compared with a group of adults with disabilities ($n = 117$). These adults were recruited by mail through a statewide disability advocacy group. Eighty-eight percent were Anglo, 54% male, average age was 44 years, and 46% were employed full time. The participants reported twenty-two disabling conditions. Internal consistency reliabilities using Cronbach's alpha for this sample were .91, .76, .90, .86, and .77 for total scores, and the Nutrition, Exercise, Psychological Well-Being, and Responsible Health Practices subscales, respectively. The adults with disabilities reported a significantly lower total score on the Self-Rated Abilities Scale than the health fair attendees ($t = 2.40$, $p < .01$, $df = 303$). The health fair sample scored higher on all subscales except Responsible Health Practices. Only the differences on the Exercise and Nutrition subscales were statistically significant.

Table 1. Correlations of Self-Rated Abilities Scale with scores on the Barriers to Health Promoting Activities scale and the Health-Promoting Lifestyle Profile for undergraduate sample (n-111)

Health-Promoting Lifestyle Profile	Self-Rated Abilities for Health Practices Scale				
	Total	Nutrition	Psychological Well-Being	Exercise	Responsible Health Practice
Total	.69	.55	.65	.53	.63
Nutrition	.41	.48	.33	.31	.29
Self Actual	.61	.47	.65	.42	.56
Stress Mgt.	.49	.30	.55	.35	.48
Exercise	.47	.38	.32	.58	.28
Health Resp.	.51	.42	.41	.36	.57
Int. Support	.50	.31	.56	.35	.49
Barriers to Health Promotion	-.55	-.47	-.39	-.54	-.47

Table 2. Comparisons of Mean Self-Rated Abilities for Health Practices Scale(SRAHP): Scores of Disabled Persons and Health Fair Sample

SRAHP Scale	Health Fair Sample (n=188)		Disabled Sample (n=177)		T-Values
	Mean	S.D.	Mean	S.D.	
Exercise	19.88	6.38	16.68	7.62	3.80
Nutrition	22.15	4.53	20.59	5.02	2.74*
Health Practices	22.55	4.63	22.80	4.16	.49
Psychological Well Being	20.10	5.33	19.79	4.99	.51
Total SRAHP Score	84.69	16.91	79.87	17.03	2.40*

*t-test value significant at $p < .01$, one-tailed test

References

Becker, H., Stuifbergen, A., Oh, H., & Hall, S. (1993). Self-rated abilities for health practices: A health self-efficacy measure. *Health Values, 17*(5), September/October, 42-50.

Callaghan, D. (2006). The influence of growth on spiritual self-care agency in an older adult population. *Journal of Gerontological Nursing, 32*(9), September, 43-51.

Publications

Stuifbergen, A.K., Seraphone, A., Harrison, T., & Adachi, E. (2005). An explanatory model of health promotion and quality of life for person with post-polio syndrome. *Social Science and Medicine 60*, 383-393.

Stuifbergen, A.K., Becker, H., Blozis, S., Timmerman, G., & Kullberg, V. (2003). A randomized clinical trial of a wellness intervention for women with multiple sclerosis. *Archives Physical Medicine and Rehabilitation 84*, 467-476.

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Warms, C.A., Belza, B.L., Whitney, J.D., Mitchell, P.H., & Stiens, S.A. (2004). "Lifestyle physical activity for individuals with spinal cord injury: A pilot study. *American Journal of Health Promotion 18* (4), 288-291.

Terms of Use

The SRAPH is free to the public and does not require permission to be used, but should not be sold. The authors ask that the source of the SRAPH be cited in research publications: Becker, H., Stuifbergen, A., Oh, H., & Hall, S. (1993). Self-rated abilities for health practices: A health self-efficacy measure. *Health Values 17*(5), September/October, 42-50. Potential users of the SRAPH are cautioned that this instrument was intended for application to persons with disabilities. As a result, when it is used with non-impaired adults, SRAPH scores have a "ceiling effect." Users should be aware that any modification of the SRAPH might alter its reliability and validity, which would consequently need to be reassessed. For questions, [email Heather Becker](mailto:heather.becker@utexas.edu), PHD.

Translations

Jones, E.G., Mallinson, R.K., Phillips, L., & Kang, Y. (2006). Challenges in language, culture, and modality: Translating English measures Into American Sign Language. *Nursing Research*.

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[Click here to download the SRAHP Spanish Translation of Auto Scale of Assessment for Health Practices](#) (Word Format).