Editorial

Proposing the Concept of Perfection Quotient as a Measure of Readiness for Health Behavior Change

Manoj Sharma

Department of Behavioral & Environmental Health, Jackson State University, Jackson, MS 39213, USA

Address for correspondence: Manoj Sharma, Department of Behavioral & Environmental Health, Jackson State University, Jackson, MS 39213, USA. E-mail: manoj.sharma@jsums.edu

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Abstract

Intelligence quotient (IQ) has been used for a long time to test for readiness of individuals with regard to their learning abilities. It offers limited utility in ascertaining readiness toward health behavior change. Work on emotional quotient (EQ) and X quotient (XQ) has been done in recent years but has not been applied for determining readiness toward health behavior change through health education and health promotion interventions. The purpose of this editorial is to propose a novel concept of perfection quotient that integrates IQ, EQ, and XQ for ascertaining the readiness for health behavior change through health education and health promotion interventions in a variety of target populations. Such measure will be invaluable in ameliorating the impact of health education and health promotion interventions.

Keywords: Emotional quotient, Health behavior change, Intelligence quotient perfection quotient

Introduction

Intelligence measures and their role in readiness for educational programs have been studied for a long time. It was the psychologist, Alfred Binet, who was first commissioned by French government in the early 1900s to develop a test for identifying students who needed educational assistance. He teamed up with Theodore Simon and came up with the measurement of intelligence in the form of intelligence quotient (IQ).[1] Stanford psychologist, Lewis Terman, adapted the Binet-Simon scale in the United States in 1916 and was called the Stanford–Binet Intelligence Scale which became the standard intelligence test in the early part of 1900s.[1] Later, Wechsler Intelligence Scales for adults, children, and other subgroups were developed.[2] These days IQ tests generally measure abilities of reasoning, problem-solving, planning, abstract thinking, judgment, and learning.[3] Intelligence is a function that is physiologically governed by the activity in the cerebral cortex. IQ as a construct for health education and health promotion interventions is important mainly in terms of providing a grasp on comprehensibility of the knowledge component for health behavior change interventions for different levels of learners. Often, this is done through designing knowledge-based educational materials at different grade levels depending on the intellectual abilities of the learners. It is generally well accepted now in the field of health behavior research that knowledge is necessary but not sufficient for health behavior change interventions.[4] Most of the time, the knowledge component is well known among participants requiring health behavior change. For example, the knowledge that smoking is injurious to health is practically known by almost all smokers, yet they engage in smoking. Hence, IQ offers a limited but fundamental basis in ascertaining readiness for health behavior change through health education and health promotion interventions.

Another concept that has received attention is that of emotional intelligence often labeled as emotional quotient (EQ).[4] Emotional maturity is the core of emotional intelligence and is considered as important as or even more

important than intelligence in determining readiness for health behavior change. Physiologically, as opposed to the cerebral cortex which is responsible for IQ this is primarily driven by the limbic system. In 1990, Peter Salovey and John D. Mayer first devised the term emotional intelligence to describe it as a type of social intelligence that involved the abilities of self-observation and regulation of feelings or affect, identifying feelings in others and using this information to modulate self-thinking and behavior.[5] Daniel Goleman further built this concept and postulated it to be more important than IQ in predicting academic achievement and occupational eminence.[6] This concept has now been broadened to include it as part of a wider conceptualization called "cultural intelligence."[7] The concept of emotional intelligence can be broken down into five constructs.[4] The first construct is that of self-awareness. It involves identifying one's emotions as they occur. The second construct is mood management. This comprises appropriately dealing with feelings as they arise so that they do not cause harm to self or others. The third construct is self-motivation. This requires one to direct feelings toward goals and in the process overcoming any potential self-doubt, lack of drive, or spontaneity. The fourth construct is empathy. This necessitates recognizing the feelings in others by observing their verbal and non-verbal forms of communication. The final construct is called managing relationships. It comprises appropriately handling interpersonal dealings, resolving any possible conflicts by compromising, avoiding, negotiating, or other means. Emotional intelligence has been studied in the contexts related to health education and health promotion, and there are several examples of such studies.[8-11] Recent work with multi-theory models (MTMs) based on collective intelligence in health behavior research has also used this concept. For example, the MTM of health behavior change conceptualizes this as emotional transformation construct that is vital for sustenance of health behavior change.[12] This concept is also important in ascertaining readiness for health behavior change in health education and health promotion interventions as the participants need to be able to gauge their emotions and that of people around them though it has not been used in this context.

A third development in the area of developing quotients as indices to predict human performance is the recent interest in X quotient or XQ.[13] This represents the recent trend of employer assessments to test potential employees in several personality traits that are deemed to predict success in potential job performance in particular situations. The constructs of XQ vary for different job requirements. Some constructs have received attention depending on the type of job. One such construct is spontaneity that includes following one's instincts, being driven by impulsivity, doing things at the spur of the moment, going with the flow and being unpredictable as opposed to planning things, scheduling things, and not engaging in anything that is not planned. In some jobs that require creativity and flexibility, this construct may be more useful compared to others. Determining levels of spontaneity may be important for assessing readiness for health behavior change as the more this is present the less a person may be ready for health behavior change. Another construct is independence that includes ability to work alone, not relying on others in performing the job, working without distractions, considering meeting with others a waste of time as opposed to being described as a social person, spending lot of time with friends, and enjoying working on teams. This trait may be useful in some jobs such as jobs that require one to work primarily by oneself such as research. In ascertaining readiness for health behavior change, this construct may be important as it emphasizes an important trait in making behavior change. Another construct is competitiveness characterized by high drive to compete as opposed to cooperative approach. This trait may be more useful in jobs such as sales or other endeavors requiring one to excel over others while the trait of cooperativeness may be more important in jobs that require team work. This construct of competitiveness may also be important for readiness toward health behavior change when one competes with oneself and not others in goals of self-improvement. XQ seems important for ascertaining readiness for health behavior change in health education and health promotion interventions as it provides insights into important traits but has not yet been used.

Based on these indices, I propose a perfection quotient (PQ) that integrates these quotients and also includes a spiritual dimension of love consciousness which would be quite useful in ascertaining readiness for health behavior change in health education and health promotion interventions. Why I want to call this as PQ is because I believe all of us consciously or unconsciously and knowingly or unknowingly are aiming toward perfection. The definition of health as promulgated by the World Health Organization also describes this perfection or ideal state when it defines health as, "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[14] The entire philosophy of health education and health promotion about behavior change also aims for this perfection where it wants people to give up on risky unhealthy behaviors and inculcate protective healthy behaviors.[15] Efforts in health education and health promotion aspire for such a utopian ideal. I suggest that PQ should include the essence of IQ in terms of operationalization of basic cognitive ability in assessing readiness toward behavior change goals, the essence of EQ in terms of the ability to identify emotions or feelings in self and the ability to transform these toward healthy goals, the essence of XQ that emphasizes low spontaneity, high independence, and competitiveness with oneself which are important precursors of readiness for health behavior change. The final linking should be done by spiritual dimension that includes the construct of love consciousness or the ability to feel, think, and exhibit love in one's interactions with self and others. The importance of love has been underscored by several researchers. Katie Eriksson from Abo Akademi University in Finland talks about a reorientation in caring sciences since the 1990s toward a more humanistic orientation and emphasize the value of serving with love.[16]

The construct of love has also been underscored by several other writings.[17-20] Future work on this measure of PQ needs development of a scale that operationalizes these constructs for the measurement of readiness toward health behavior change and its application in different health behaviors in different target populations.

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