

Theoretically Speaking: Overview and Summary of Key Health Education Theories

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Say you are responsible for addressing a health problem that affects many people. Your challenge is to design an intervention to prevent or remediate that health problem. Where do you start?

Assuming that you did not shout out “With theories, of course,” we have written this column to promote the use of theories right from the very beginning and to provide a summary of some of the key theories being used in health education and promotion today. If you want more, let us know.

We hope that the first thing you do when confronted with a health problem is to ask “Why does this problem exist?” and to try to answer this question by identifying all behaviors or circumstances that might cause or be associated with the problem. However, some of us tend to immediately focus on figuring out which personal behaviors or actions are jeopardizing the person’s health without looking at why those behaviors are happening. We put it all on the individual with the problem! In short, we “blame the victim.”

In spite of the important role of personal responsibility in health, we need a broader approach—a comprehensive, multidimensional, ecological approach—if we are to effectively influence health and health behaviors. Theories related to different levels of causation can help.

LEVELS OF HEALTH PROBLEM CAUSATION

1. A person’s knowledge, attitudes, and skills (intra-personal level)

2. The beliefs and actions of a person’s friends, family members, coworkers, and other referents (interpersonal level)
3. The policies and practices of the civic, religious, social, political, and related organizations with which the person is affiliated (institutional or organizational level)
4. The attributes, resources, and norms of the community with which the person is affiliated (community level)
5. The content of public policies, laws, and regulations that affect the person (public policy level).

WHERE IDEAS FOR POSSIBLE CAUSES ORIGINATE

Theories!

WHAT ARE THEORIES?

Theories are summaries of formal or informal observations, presented in a systematic, structured way, that help explain, predict, describe or manage behavior.

CORE COMPONENTS OF THEORIES

- Explanatory factors
- Descriptions of the relationships among these factors
- Definitions of conditions under which these relationships exist and do not exist

ATTRIBUTES OF THEORIES

- Are evidence-based

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- Are supported or refuted by evidence, not proven or disproven
- Hold the middle ground within a “hierarchy of certainty”; reflect a level of uncertainty that decreases as supporting evidence is amassed
- Reflect more certainty than hypotheses and models but less certainty than principles and laws (i.e., of gravity and thermodynamics) for which there is overwhelming supportive evidence
- Change with new observations and/or evidence
- Are, to a relative degree, generalizable
- Are testable so that people can “try them on for size” and “see if they fit”
- Come from all scholarly disciplines
- Offer frameworks for understanding situations and identifying strategies to manage them
- May have similar explanatory factors
- May have explanatory factors that differ dramatically and incorporate unique variables that shed new light on a situation
- Are not guarantees
- Are subject to change based on new evidence
- May be applied singly and/or in combination to behavior change challenges
- Should be enhanced with our own creativity and insight

CAVEAT!

There is no one right or best theory.

CRITERIA FOR CHOOSING THEORIES

- The level at which the cause occurs (intrapersonal, group, institutional, community, or public policy). There are relevant theories at all five levels.
- The setting in which the problem occurs
- The site where you will offer the intervention
- The population of concern
- The behavior itself: its complexity or simplicity, the degree of frequency with which it is performed, and so forth

BENEFITS OF THEORIES

- Help us understand what influences health behaviors and to plan, based on that insight, effective interventions (such as health education programs and materials; organizational services, products, practices, and procedures; community-wide strategies; and public policy changes)
- Help us identify what data to collect when assessing a situation related to a health problem—if we know or suspect that certain variables (suggested by a theory) are involved, we look for information related to those variables (guide needs assessments)

- Help us select intervention participants
- Serve as guides for selecting or developing and implementing and/or applying interventions for working with specific populations
- Help us predict what consequences various interventions are likely to have, even in situations we have never before encountered
- Guide us in identifying and selecting intervention evaluation methods and measures
- Save time and money
- Increase our confidence in what we are doing
- Provide a basis for more research

A POLICY-LEVEL THEORY

Media Advocacy

Proponent: Larry Wallack

To achieve behavior change to a truly significant degree, it is often more effective to address the policy that drives the problem rather than the problem itself. Public concern can be stimulated and policies changed by (a) identifying the initial perception of a health problem, (b) redefining or reframing it to focus on a related policy rather than personal behaviors, (c) presenting it to the media in this new light, (d) providing supporting information and feature and/or news stories, (e) being accessible for questions from media representatives, and (f) reinforcing this different perception of the original health problem.

COMMUNITY-LEVEL MODELS AND THEORIES

Community Organizing Models

Proponent: Jack Rothman

Community organizing (a process in which community groups identify problems, mobilize resources, and design and implement strategies to achieve common goals) can focus on solving immediate problems, building a sense of community and community capacity, and/or redistributing power and resources. If the primary concern is short-term problem solving, the social planning model suggests using a task-oriented approach that involves calling in an outside technical expert. If the goal is to foster a sense of community and to build skills, the locality development model, a collaborative, consensual, process-oriented approach, suggests involving a broad cross section of people from the community in task forces to determine and solve community problems. If the primary concern is about shifting power relationships and resources within a community,

social action, a more confrontational, conflict-oriented model, may be appropriate. Often, situations call for the use of a combination of these models. Newer models focus on collaborative empowerment, community regeneration, community building, culture, and coalition building. They promote building on the strengths and gifts of communities and their members and/or groups.

ORGANIZATIONAL-LEVEL THEORIES

Stage Theories

There are many organization-based planned change implementation theories. Most of them are based on “stage theories,” which assume that organizational change requires progress through the following series of stages: (a) sensing unsatisfied demands on a system, (b) searching for possible responses, (c) evaluating alternatives, (d) deciding to adopt a course of action, (e) initiating action within the system, (f) implementing the change, (g) institutionalizing the change, and (h) re-evaluating the change. The change agent’s job is to facilitate four procedures—problem diagnosis, action planning, intervention, and evaluation—using specific organizational development techniques.

AN INTERPERSONAL-LEVEL THEORY

Social Learning Theory

Proponent: Albert Bandura

Rather than put the onus of behavior change only on the knowledge, attitudes, and skills of the individual whose behavior we want to change, social learning and/or cognitive theory assumes that there is a connection—an interdependence—among (a) the characteristics of the person whose behavior is targeted for change, (b) the attributes of the behavior itself, and (c) the environment in which the behavior is to take place. This is called *reciprocal determinism* and means that what someone does depends on the characteristics of the person, the nature of the behavior, and the characteristics of the environment. Changing behavior depends on changing aspects of one or more of those three factors. The theory also says that if a person has three things—confidence in his ability to perform a new behavior (behavioral capability), the skills and knowledge necessary to perform that behavior (self-efficacy), and a strong belief in the value of the expected outcome(s) of the new behavior (outcome expectancy)—the more likely that person is to (a) decide to

adopt the recommended behavior, (b) put effort into doing the new behavior, and (c) persist in doing the new behavior than is someone without these three characteristics. Unlike some other theories, this theory recommends specific strategies (direct and vicarious experience) for increasing behavioral competence, self-efficacy (personal mastery of the task, observing the performance of others, receiving suggestions from others, and dealing with emotions triggered by thoughts of the change), and outcome expectancies (direct, vicarious, and self-managed rewards).

Diffusion of Innovation

Proponent: Everett M. Rogers

According to diffusion of innovation theory, five key factors influence whether and at what rate an innovation will be diffused within a system: (a) individual characteristics of the prospective adopter (is the adopting unit a member of the innovator, early adopter, early majority, late majority, or laggard adopter category), (b) the environmental context into which health educators introduce the innovation, (c) the change agent who is promoting the innovation (is the person credible, trusted, respected, liked, and associated with a sponsoring agency that also is?), (d) the quantity and quality of information and communication about the innovation available to the adopters, and as is becoming increasingly evident, (e) characteristics of the innovation itself: Is the new behavior perceived by the client as superior to the current behavior or inactivity (relative advantage)? Is the new behavior perceived by the client as compatible with client needs, values, and experiences (compatibility)? Is the new behavior perceived by the client as easy to do (complexity)? Is the new behavior perceived by the client as divisible—able to be implemented one step at a time (trialability)? Is the new behavior perceived by the client as producing immediately observable results (observability)? Additional important concepts include the adoption curve, the idea of adoption curve thresholds, and the innovation-decision process.

Empowerment

Proponent: Paolo Freire

Empowerment theory suggests that a problem-posing process can help clients overcome their sense of powerlessness, thus freeing them to make healthy choices. If members of a population (a) come together to see a dramatic presentation by group members in the form of

role plays, stories, slides, photographs, or songs; (b) participate actively in an open-ended problem-solving dialogue about those issues raised by the drama (by participating in a facilitated five-step process that includes asking individuals to describe what they see in the representation and what feelings it calls up; defining, as a group, the many levels of the problem; sharing similar experiences from their lives; questioning why this problem exists; and developing an action plan to address the problem); and (c) implement that action plan that addresses the problem at a community level, behavior change will happen eventually. The most important result is permanent personal and community development.

SAMPLE INTRAPERSONAL-LEVEL THEORIES

Health Belief Model

Proponents: Geoffrey Hochbaum and Irwin Rosenstock

A person who (a) perceives a certain condition (that a recommended behavior is said to prevent or minimize) to be a threat (because the condition is serious and the person feels susceptible to it), (b) is cued by people or messages in the environment to perform the behavior, (c) has confidence in his ability to carry out the behavior, and (d) believes the benefits of doing the behavior outweigh the disadvantages, barriers, or negative consequences is more likely to perform the behavior than someone without those beliefs.

Theory of Reasoned Action

Proponents: Icek Ajzen and Martin Fishbein

A person who thinks a recommended behavior produces a certain outcome and feels that that outcome is desirable (attitude) and knows what important people in his or her life (people's whose opinion on this matter really count) feel about this recommended behavior and is sufficiently motivated to comply with those people (subjective norm) will intend to make a behavior change and therefore will make the behavior change. The relative importance of attitude and subjective norm varies depending on the population involved and will influence behavioral intention.

The Theory of Planned Behavior

Proponents: Icek Ajzen

Based on the theory of reasoned action, this theory adds one other factor to the mix: perceived behavioral control. A person who (a) thinks a recommended be-

havior produces a certain outcome and feels that outcome is desirable (attitude), (b) knows what important people in his or her life (people's whose opinion on this matter really count) feel about this recommended behavior and is sufficiently motivated to comply with those people (subjective norm), and (3) has high self-efficacy (a subjective sense of self-confidence) in his or her ability to change and a high objective sense of control over the conditions (facilitating and constraining) that affect intention and behavior (perceived behavioral control) will (d) intend to make a behavior change and therefore (e) will make the behavior change.

Transtheoretical Model and/or Stages of Change

Proponents: James Prochaska and Ralph DiClemente

Behavior change is a process that can be triggered by the use of stage-matched interventions as follows: If a client is unaware that he or she has a problem and has no intention of taking action in the next 6 months (precontemplation), the appropriate intervention is to increase client awareness of the need for change and to personalize information on risks and benefits while increasing and promoting the benefits of changing. If the client is thinking about changing in the near future and intends to take action within the next 6 months (contemplation), motivate the client; encourage specific plans and decrease and reduce the cons of changing. If the client is making plans to change, intends to take action within the next 30 days, and has taken some behavioral steps in this direction (preparation or commitment), assist the client in developing an action plan and setting goals. At this point, the pros and benefits must be perceived as outweighing the cons, costs, and risks. If the client is implementing a specific action plan and is changing or has changed overt behavior for less than 6 months (action), provide the client with feedback, social support, reinforcements, and help with problem solving. If the client continues to do the desired action or is repeating periodic recommended step(s) and has changed overt behavior for more than 6 months (maintenance), then help the client prepare for, avoid, or handle relapse; help with coping, reminders, finding alternatives when faced with behavior-related challenges, and continue action-matched interventions. If the client has been doing the new behavior for so long that the client can hardly remember doing or can hardly imagine ever having done the old behavior (termination), continue providing, as necessary, maintenance-matched interventions.

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