A Review of Current Health Education Theories

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Abstract

This article presents a review of current theories and models in health education. Articles published in 2003 in the American Journal of Health Education, the American Journal of Health Behavior, Health Education and Behavior, Health Education Research, and the International Electronic Journal of Health Education, were reviewed. Concepts and constructs for each theory and model used are presented. The three predominant theories and models in this literature, The Transtheoretical Model (Stages of Change Theory), the Theory of Reasoned Action/Planned Behavior, and the Social Cognitive Theory are examined in greater detail.

At times, beginning and even accomplished practitioners fail to acknowledge that much of what they do in their daily activities is rooted in a tremendous amount of study and research on the part of pioneers who went before them. Often in the search for practical ideas, theory is treated dismissively. It's interesting, but academic. Practitioners frequently succeed at intuiting the concepts, constructs and relationships of behavior, and applying this knowledge without recognizing that what they are doing has a basis in theory. This however, is a much less efficient approach than beginning with a conscious theoretical base from which to draw, and having that base to illuminate our work.

Theory plays an essential role in Health Education as a profession. According to Upton (1970, as cited in Taub, 1998), theory is one of the defining characteristics of a profession. The Coalition of National Health Education Organizations (CNHEO) publication, “The Health Education Profession in the 21st Century: Progress Report 1995-2001,” states that “Dynamic and Quality practice and research applies state-of-the-art theory and technology in the design, implementation, and evaluation of health education programs” (2001, p. 44). Theories and models are among health educators’ most useful tools as they tackle the challenges of: a) needs assessment, b) program planning, c) program implementation, d) program evaluation, e) coordination of services, f) acting as a resource of health information, and g) communicating needs, concerns, and resources outlined in the Framework (Alperin & Miner, 1993; National Task Force on the Preparation and Practice of Health Educators, 1985).

According to Babbie (2003), theory is defined as “A systematic explanation for the observations that relate to a particular aspect of life” (p. 12). Models on the other hand are best defined as “… a subclass of theory” (McKenzie & Seltzer, 2001, p. 138). While theories are organized around ideas, concepts, and constructs, models are representations of theory. “Models provide the vehicle for applying the theories” (McKenzie & Seltzer, 2001, p. 139). A theory, capable of full explanation of something as complex as human behavior, would be far too cumbersome to be useful. And thus we come to the criteria for useful theory: internal consistency, parsimony, plausibility, pragmatism and ecological validity (Glanz, Lewis, & Rimer, 1997). The elegant simplicity required of theory necessitates that health education practitioners are conversant with a number of theories,
enabling them to choose the most appropriate for the specific situation (Glanz, Lewis, Rimer, 1997).

The purpose of this article is to provide an overview of the theories and models currently being used in the field of health education. To address the issue of currency, the author reviewed theory-based articles published in 2003 in the following journals: the American Journal of Health Education, American Journal of Health Behavior, Health Education and Behavior, Health Education Research, and the International Electronic Journal of Health Education. Seventeen different theories were used to explain a wide variety of human behaviors, including pedestrian safety, physical activity, obesity, drug use, sexual behaviors, violence, vaccinations, organizational challenges, osteoporosis prevention, condom use, alcohol abuse, racial, ethnic and gender disparities, leisure activities, sunscreen use, use of complimentary and alternative medicine, tobacco use, sugar restriction, nutrition education, smoking, chronic illness management, hormone replacement therapy, soft drink consumption, environmental policy, family planning, and screening for colorectal cancer. These articles have been indexed in Appendix A, according to their theoretical base.

Some of the articles reviewed have their base in more than one theory or model. In 2003, stage theories/models were used most frequently. The Transtheoretical Model/ Stages of Change Theory served as a base for 17 articles, while the Theories of Reasoned/Action and Planned Behavior were the focus of 12 articles. Social Cognitive Theory/Social Learning Theory, which is used for understanding interpersonal health behavior was a base for 11 of the articles. The rest of the theories were cited five times or less. These include the Diffusion of Innovation Theory (five), Social Support/Social Capital (four), Health Belief Model (four), Coping Theory (two), Organizational Theory (two), and the remaining theories with one article each—Cognitive Dissonance Theory, the Elaboration Likelihood Model, Locus of Control, Piaget’s Theory of Child Development, the Precaution Adoption Model, the Precede-Proceed Model, Protection Motivation Theory, Systems Theory, and the Theory of Interpersonal Behavior. Three theories/models, the Transtheoretical Model alternatively known as the Stages of Change Theory, the Theory of Reasoned Action/Planned Behavior, and the Social Cognitive or Social Learning Theory, accounted for over half of the theoretical applications in these selected health education journals. Therefore, within this article, we will focus on these three theories/models. But first, we will examine four distinct categories of health theories and models: individual health behavior, interpersonal health behavior, group intervention, and staged models and theories.


All of these theories seek to interpret or analyze health behaviors at the individual level, where intention is independent of the overt actions of others. Among this group of theories, Festinger’s (1957) Cognitive Dissonance theory is noticeably different. Festinger’s work does not focus on outcome expectation or threat, but instead focuses on the consonance between thought and action. Festinger posited that when this equilibrium is disrupted, one acts to restore the balance. Either the behavior or the attitude must change so that they are in concert with one another. The remaining theories make outcome expectations explicit as constructs, by assessing health threats, susceptibility, and the potential for efficacy of action.
### Table 1

**Individual Health Behavior Theories/Models**

<table>
<thead>
<tr>
<th>Theory</th>
<th>Originator(s)</th>
<th>Field of Study</th>
<th>Key Concepts and Constructs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Belief Model</td>
<td>Godfrey, Hochbaum, Irwin, Rosenstock, 1950’s</td>
<td>Psychology</td>
<td>Perceived threat, Perceived susceptibility, Perceived severity, Benefits and barriers to taking action, Cues to action, Self-efficacy</td>
</tr>
<tr>
<td>Theory of Reasoned Action/Planned Behavior</td>
<td>Ick Ajzen &amp; Martin Fishbein, 1969 TPB evolved from TRA</td>
<td>Psychology</td>
<td>Behavioral intention, Attitude, Outcome expectancy, Evaluation of likelihood of outcome expectancy, Subjective norm, Normative beliefs, Motivation to comply, Perceived behavioral control, Control beliefs, Actual behavioral control</td>
</tr>
</tbody>
</table>

Among the interpersonal health behavior models are Alfred Bandura’s Social Cognitive Theory (Bandura & Walters, 1963; Bandura, 1969, 1977a, 1977b), H. C. Triandis’ Theory of Interpersonal Behavior (1977, 1980, 1994, 1995), the combined works of Gordan Caplan (1974), S. Cobb (1976), J. S. House (1981), R. L. Kahn and T. C. Antonucci (1980) in social support, and coping, the works of Barbara S. Wallston, Kenneth A. Wallston, Gordan D. Kaplan, and S. A. Maides (1976; Wallston Maides, & Wallston (1976).) concerning Locus of Control, and Richard Petty & John Cacioppo’s Elaboration Likelihood Model (Cacioppo, 1979, 1981, 1986, 1986a; Cacioppo & Petty, 1979). See Table 2. These theories move one step beyond the individual health behavior theories to consider the influence of other persons on health behavior. These theories share several concepts not only with the group theories, but also with the individual health theories. See the table in Appendix B.
<table>
<thead>
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</tr>
</thead>
</table>
Social systems, the third category of theory to be reviewed, included two articles concerned with social systems theory. One article specifically addressed General Systems Theory, which was first conceived by L. Von Bertalanffy (1950), (International Society for the Systems Sciences, n.d.). Dr. Bertalanffy was a biologist and a renowned theorist in the early 20th century. The General Systems Theory addresses the complexities and solutions of virtually every scientific field (International Society for the Systems Sciences, n.d.), but for our purposes in health education, it is applied to the sociocultural and psychological domains (Von Bertalanffy, 1976), and more specifically, to the field of social marketing (Sirgy, 1984).

The fourth grouping of health behavior theories contains what are referred to as stage theories. Piaget’s Child Development Theory (Jean Piaget Society, n.d.) describes children’s developmental stages from birth through age fifteen. Green’s Precede-Proceed Model (Green & Kreuter, 1991) is a comprehensive staged program planning model, extending from needs assessment through outcome evaluation. Only the final three models, Prochaska and DiClemente’s Transtheoretical Model (Glanz, Lewis, & Rimer, 1997; Kreuter & Lezin, 2002; Zimmerman, Olsen, Bosworth, 2000), Rogers’ Diffusion of Health Promotion Innovation (1983), and Weinstein’s Precaution Adoption Model (1988), are concerned directly with following or predicting the progress of adoption of behavior changes. Within those three, there is an overlap of concepts, which can be readily seen through examination of Table 3.

Having reviewed the different groups of theoretical research currently being used in the specified health education journals this past year, let us turn to the three theories/models most frequently used therein. These include: The Transtheoretical/Stages of Change Model, the Theories of Reasoned/Action and Planned Behavior, and the Social Cognitive Theory/Social Learning Theory.

The Transtheoretical Model was first developed in 1983 by James O. Prochaska and C. C. DiClemente (Glanz, Lewis, & Rimer, 1997; Kreuter & Lezin, 2002). The model derives from the profession of psychology and addresses five stages of behavior change. Pre-contemplation is denial or not being aware that a behavior puts one at risk. As one develops awareness of the situation, he/she begins Contemplation of taking action, considering all of the factors that go into making the decision to change a behavior. Progressing to the Preparation phase, one might line up social support, make plans of action, and purchase necessary accoutrements. The Action phase is the actual adoption of the new behavior, and the Maintenance phase is where one works to keep their acquired behavior on-track. Maintenance is a lifelong process. There is interplay between the stages, as they are not linear. As with any behavior modification regimen, occasionally one may slip back into the maladaptive behavior. Once the slip occurs, one re-enters the process. This model has the advantage of acknowledging that these slips do occur, and preparing people for these occurrences. Slips are considered mere eventualities, as they are expected, and are not seen as catastrophic events that might lead one to abandon the positive health behaviors one is attempting to acquire. Next we will examine the Theory of Reasoned Action/Planned Behavior.

Ajzen and Fishbein’s Theory of Reasoned Action (1969, 1970, 1977, 1980) predates the eventual extension to the Theory of Planned Behavior by at least twenty years. These theorists began with the interesting notion that people behave the way that they do for a reason, and thus behavior is logical. If this holds true, we should be able to explain or predict human behavior. They began by positing that the best way to predict someone’s actions, is to ask them what they intend to do within a reasonably proximal time range. Behavioral intentions are thus the best predictors of human behavior. They determined that the best predictors of one’s stated behavioral intentions lie in attitude and subjective norm. According to Ajzen and Fishbein, one’s attitude is best predicted by examining what he/she expects to be the outcome of a particular action, and his/her evaluation of the likelihood of this outcome.
Table 3. Stage Theories

<table>
<thead>
<tr>
<th>Theory/Model</th>
<th>Originator(s)</th>
<th>Field of Study</th>
<th>Key Concepts/Constructs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Piaget’s Child Development Theory Source: Jean Piaget Society</td>
<td>Jean Piaget 1950’s</td>
<td>Biology Philosophy</td>
<td>Stages 1) Sensorimotor stage (Birth to 2 Years) 2) Preoperational stage (Ages 2-7) 3) Concrete operations (7-11) 4) Formal operations (11-15)</td>
</tr>
</tbody>
</table>
Subjective norm is a generalized construct, reliant upon one’s normative beliefs (what significant others would have them do), and one’s motivation to comply with the wishes of these significant others. General criticism of the model was levied that the theory did not take into account behaviors not under the volitional control of the subject.

This was remedied with the 1985 evolution of the theory to address this aspect as planned behavior. See Ajzen (1988) for a thorough treatment of the Theory of Planned Behavior. With the addition of perceived behavioral control (ability), we see its impact on intention, the reciprocal determinism between perceived behavioral control and subjective norm, between perceived behavioral control and attitude, and between attitude and subjective norm. Ajzen notes that actual behavioral control is dependent upon resources and opportunity (Ajzen, 1991).

The final theory to be reviewed is the Social Cognitive/Social Learning Theory advanced by Albert Bandura. Bandura advanced Social Learning Theory in 1963 (Bandura, 1963, 1977, 1986, 1994; Pajares, 2002), by introducing the concepts of modeled behavior and vicarious reinforcement as learning mechanisms. It wasn’t until 1977 that he introduced the concept of self-efficacy into the theory (Bandura, 1977a, 1977b, 1986, 1994, Pajares, 2002). In 1986, Bandura introduced the idea of reciprocal determinism (Bandura, 1986, 1994; Pajares, 2002). Pajares (2002) states that Bandura’s idea of reciprocal determinism is based in “the view that (a) personal factors in the form of cognition, affect, and biological events, (b) behavior, and (c) environmental influences create interactions that result in a triadic reciprocality.” It was at this time that Bandura changed the name of the theory from Social Learning Theory to Social Cognitive Theory “…to distance it from prevalent social learning theories of the day and to emphasize that cognition plays a critical role in people's capability to construct reality, self-regulate, encode information, and perform behaviors.”

This article has provided a brief overview of several of the theories used in health education today. Although the theories were categorized here as individual, interpersonal, social systems, and staged theories, they could just have well have been organized around their many uses. They provide insight into every facet of program planning, implementation, and evaluation. They also provide us with the tools necessary to understand individual behavior, as well as the behaviors of populations we wish to serve.”

For those wishing a more complete treatment of theory as applied in health education, the texts by Glanz, Rimer, and Lewis entitled: Health Behavior and Health Education: Theory Research and Practice (2002), and Emerging Theories in Health Promotion Practice and Research: Strategies for Improving Public Health (Diclemente, Crosby, & Kegler, 2002) are recommended. Another source produced by the National Institutes of Health is Theory at a Glance. For those wanting a quick overview of a variety of health behavior change theories and models, Kelli McCormack Brown has compiled a great deal of information that can be accessed at her web site.

References


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Appendix A
2003 Articles and their Attendant Theories/Models

**Cognitive Dissonance Theory**

**Coping Theory**

**Diffusion Theory**

**Elaboration Likelihood Model**

**Health Belief Model**

**Locus of Control**
Organizational Theory

Piaget’s Theory of Child Development

Precaution Adoption Process Model

Precede-Proceed

Protection Motivation Theory

Social Cognitive Theory/Social Learning Theory
Social Support


Systems Theory

Theory of Interpersonal Behavior

Theory of Reasoned Action/ Theory of Planned Behavior


**Transtheoretical Model**


*All starred entries use more than one theory.
## Appendix B
Depiction of the Similarities Found within the Individual and Interpersonal Health Theories

<table>
<thead>
<tr>
<th>Theory/Model</th>
<th>Perception of Threat/ Expectations</th>
<th>Efficacy Internal Control</th>
<th>Outcome Expectancy</th>
<th>Enabling Factors or Barriers</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Belief Model</td>
<td>Perceived Threat Susceptibility Severity</td>
<td>Self-Efficacy</td>
<td></td>
<td>Benefits Barriers</td>
<td></td>
</tr>
<tr>
<td>Theory of Reasoned Action/ Planned Behavior</td>
<td>Outcome Expectancy Evaluation of Likelihood of Expectancy</td>
<td>Control beliefs</td>
<td></td>
<td></td>
<td>Subjective Norm Normative Beliefs Salient referents Motivation to comply with referents</td>
</tr>
<tr>
<td>Protection Motivation Theory</td>
<td>Threat appraisal Severity Vulnerability</td>
<td>Coping appraisal Self-efficacy Response-efficacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Learning Theory</td>
<td></td>
<td>Self-efficacy</td>
<td></td>
<td></td>
<td>Modeling Vicarious learning</td>
</tr>
<tr>
<td>Theory of Interpersonal Behavior</td>
<td></td>
<td>Personal factors Habit</td>
<td></td>
<td></td>
<td>Social</td>
</tr>
<tr>
<td>Social Support and Coping</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Supportive behaviors Emotional support Appraisal support Informational support Instrumental support Social capital</td>
</tr>
<tr>
<td>Locus of Control</td>
<td>Expectancy</td>
<td></td>
<td>Re-inforcement</td>
<td></td>
<td>External locus of control Powerful others</td>
</tr>
<tr>
<td>Elaboration Likelihood Model</td>
<td></td>
<td>Ability to process, Nature of cognitive processing, Persistence, Resistance</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>