Health Education and Behavior: Are School Health Educators in Denial?

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ABSTRACT

School health education has been and still is guided by a number of different and often competing philosophical orientations. The field seems to be moving toward a skills-based philosophy, but the adoption of this approach is taking place with little discussion or analysis in the professional health education literature. The purpose of this article is to propose an integrated behavioral alternative to the present skills-based trend and to encourage the health education profession to examine school health education philosophy critically. The nature and scope of the educational reform that is sweeping the country makes the need for a critical examination of school health education philosophy, with accompanying dialog about goals and purposes, crucial to the growth and viability of school health education.

"…it is suggested that health education be concerned with cognitive development while leaving attitudinal development and behaviors to other institutions in our society."[1]

"Although in the long run health education must contribute to people's health…its specific goal is to improve people's health behaviour and the measure of effectiveness is to be sought in changes of behaviour…"[2]

"I propose that health education be considered a process in which the goal is to free people so that they may make health-related decisions based upon their needs and interests as long as these decisions do not adversely affect others."[3]

"Health literacy requires educators to switch from a content-driven to a skills-driven approach. Young people need to learn, practice and apply skills successfully, numerous times, with positive reinforcement and social support to maintain personal health and safety."[4]

"The role of the health educator is to motivate students to put into practice what is learned in class, while at the same time teaching moral responsibility, conscience, and self-discipline."[5]

"…we should be including not only self-help/self-care, but also the promotion of a healthful environment, a safer work place, a caring medical care system; the promotion of public participation; the development of healthful public policy, a community approach to health status improvement, a caring and sharing philosophy, and not a focus that is overly reliant on individual effort."[6]

INTRODUCTION

In the course of its history, health education has operated under a number of different and often competing philosophical positions. The present situation is a microcosm of the past in that each of these differing positions is alive and well in various corners of health education practice today. Some might conclude that such diversity of viewpoints, or philosophies, indicates a rich, vibrant, and evolving profession. Others might argue that this situation is a sign of confusion, an indicator of unclear focus, or a complete absence of consensus on purpose. In 1995, Welle, Russell, and Kittleson,[7] conducted research to determine if there was a dominant philosophy among health educators and operationally described five philosophical positions present in health education. Those five positions were: cog-

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nitive-based, decision making, behavior change, freeing/functioning and social change. These positions continue to serve as the basis of philosophical discussions in health education professional preparation programs at the graduate and undergraduate levels across the nation.

It is clear that having an understanding of the major health education philosophies and a grasp of philosophical trends is extremely important.[7] However, it is also important to recognize that of the five positions described in the Welle, et al., article, the behavioral philosophy seems to provide school health education in a K–12 setting with the most reasonable and supportable position from which to operate in today's climate. The apparent lack of focus, or consensus, that characterizes school health education philosophical discussions seems more related to denial than to establishing a positive diversity of thought. It is the authors' position that by adopting non-behavioral philosophies, these K–12 school health educators are denying the importance of their role in influencing youth behavior, ignoring the needs of students and failing to address the expectations of parents and communities.

Philosophical orientations that focus on such outcomes as skills development, knowledge, attitudes, values, social factors, or similar ends deny the centrality of behavior as the "appropriate" philosophical foundation for school health education practice. Philosophies that support such school health education program outcomes as knowledge gain, attitude change, or value development alone do not accurately reflect current health education needs, such as meeting *Healthy People 2010* objectives.[8] As school health education competes for instructional time and budgetary dollars, it is crucial that the field has a clear, consistent, and supportable operating philosophy that reflects individual and societal health needs, identifies an important and relevant purpose, and emphasizes its unique contribution to children and schools. Failing to acknowledge the importance of behavior in health education programming makes this task very difficult.

The search for a coherent, understandable, and defensible philosophy of health education is not a new area of scholarship. Unfortunately, the past high level of interest in philosophical discourse and debate seems to have diminished. When articles have been written, or presentations given, that offer a clear and thoughtful philosophical position,[5,6,9,10,11] they seem to have created very little professional dialogue at the national level. A specific, recent example of this silence can be observed in the lack of discussion surrounding the promotion and acceptance of the skills-based philosophy. This philosophy appears to be gaining in popularity, but is being accepted with very little critical analysis in the professional literature. It seems as though health educators are either no longer interested in such a discussion, or have concluded that the different and sometimes contradictory philosophical positions can exist side by side, or have decided that the best that can be accomplished is to "agree to disagree."

This current situation is both disappointing and professionally dangerous. It is disappointing because debating differing points of view, which is related to the professional self-criticism that Carlyon once described as "critical dialogue,"[12] can advance professional thinking, refine ideas about mission, and help a profession reinvent itself in the face of changing times and issues. This situation is dangerous because philosophical thought is central to the development and delivery of health education. For a profession to stay vital and relevant, it is important to assess its activities, regularly evaluate its goals, and assess its philosophical direction. This article is an attempt to help stimulate such an examination and to propose a behaviorally focused, ecologically grounded, integrated philosophy for school health education.

There may be some support for the viewpoint that a philosophy should be broad enough to apply to health education regardless of practice setting. After all, the responsibilities and competencies that emerged from the Role Delineation Project[13] apply to all settings and have served to provide some unified face to health education. Although it is clear that the CHES "generic" skills and competencies can serve as a foundation for achieving outcomes that are related to a variety of philosophical positions, the same cannot be said about the application of a "generic" philosophy to a variety of practice settings. The "real world" is composed of many different delivery sites, clients and practitioners, and a "one size fits all" philosophy is neither realistic nor appropriate. Therefore, the focus of this paper is on *school* health education and on a philosophy to guide *school* health education practice.

An Integrated Approach to Philosophy: First Some Background

A problem with trying to view health education philosophy from an integrated perspective is that this orientation is not consistent with either past or present approaches. The profession traditionally has focused on *differences* in philosophical thought, rather than looking for commonalities and trying to develop a perspective that would accommodate very different viewpoints. Looking at the application of four of the "traditional" philosophies in school health education can help in understanding where schools have been and where they need to go.

The view that the role of health education is to disseminate information, increase the knowledge base, or provide the student with information needed to make decisions has been a long-standing health education philosophy. The *cognitive-based philosophy* can be traced back to Mann and Shattuck at the dawn of school health education.[14] Information acquisition as the mission of the schools has been supported in the past by Greenberg[1] and was more recently discussed in a paper by Gold and Kelly.[9]

The *skills development philosophy* focuses on the importance of students developing skills that could be applied in a variety of health-related settings. Similar to the decision-making approach supported by Kolbe, Iverson, Kreuter, Hochbaum, and Christensen,[15] the criterion for a successful

program under the skills-based philosophy is the degree to which a student can perform a skill in the classroom. The skills-based approach appears to be the direction being taken by many school health education programs and can be clearly observed as a driving force behind the National Health Education Standards,[16] in state level health education documents[4,30,32] and in health education textbooks.[17]

To some extent, influencing health-related *behavior* has been a rationale for health education for as long as schools have been involved with the health programming. For example, it can be observed in the type of health education that grew out of the Temperance Movement of the late 1800s,[14] the health habit development approach of the early 1900s,[18] portions of the *Report of the President's Committee on Health Education,*[19] and in Hochbaum's[2] quote at the beginning of this paper. Examples of interest in behavior and behavioral outcomes can be observed in sex education with such programs as "Reducing the Risk" and "Postponing Sexual Involvement."[20] More recent examples include a focus on preventing or reducing childhood obesity and the widespread application of behavior-based data collection as is illustrated by the Youth Risk Behavior Survey.[21]

At the heart of the *social change philosophy* is the belief that health education needs to consider societal, environmental, and social factors in its programming for influencing health, rather than narrowly focusing on the individual and personal attributes such as knowledge, skills, attitudes, values, and behaviors.[6,10,11] Recognition of the importance of a societal/environmental perspective is not new to the general field of health education and can be observed readily in the early ecologic model of health proposed by Hoyman,[22,23,24] writings by Minkler,[10,11] the orientation and conceptual framework underlying the PRECEDE/PROCEED Model,[25] and in O'Rourke's 1988 AAHE Scholar's address.[6] The Coordinated School Health Program Model[26] provides many opportunities to implement this philosophy, but outside of this model, the school health education literature shows little interest in discussing this perspective.

A variety of different authors have proposed, supported, or described other philosophical directions or themes for school health education. Some of these themes included values clarification, affective education,[27] freeing and functioning,[3,7] character education,[28,29] and moral development.[5] Although these orientations may have played some role in health education, they have not been as significant as those already discussed or they may be more reasonably viewed as a part of another more dominant philosophy.

An Integrated/Ecological Behavioral Philosophy of Health Education

In simple terms, the philosophy that is being proposed is focused on influencing health-related behavior. This philosophy, in addition to being behavior-based, is ecologically grounded and integrates outcomes of other philosophies as steps or mediators needed to influence behavior. The *behavioral focus* of this philosophy means that the purpose and goal of health education is to influence the health-related behavior of students. The *ecologic focus* or orientation means that the process of health education must be multidimensional, recognizes that the individual and the environment are interdependent, and conceives of health and health status as the result of interactions between the individual and the environment.[22,23,24] Stated another way, "…because health and health risks are determined by multiple causes, efforts to effect behavioral, environmental and social changes must be multi-dimensional or multisectoral."[25] The *integrated dimension* of this behavioral philosophy views the desired outcomes of other philosophical perspectives (e.g., knowledge or skills) not as ends in themselves, but as integral mediators of the behavioral outcome.

Since a philosophy of health education should serve as the framework from which everything in a program emanates, the process of health education under this proposed philosophy focuses on promoting health-enhancing *behaviors*, operates from a broad *ecological* perspective and *integrates* sound thinking from other philosophies. Therefore, under this behavioral philosophy, the process of health education involves:

- Encouraging the adoption of health-enhancing lifestyles.
- Focusing on content and experiences designed to affect understandings, beliefs, attitudes, values, practices, and behaviors.
- Identifying consequences of health-threatening behaviors.
- Providing class activities to develop health-related skills.
- Working to create an environment that supports and promotes health-enhancing behavioral choices.

Professionals who have not thought philosophically about health education or parents who are trying to understand the process of health education might look at this description and conclude that the statement is rather intuitive, asking, for example, "Isn't this what school health education has been doing all of these years?" The answer to this question is yes and no. To be sure, there are health educators who may have been operating in this manner and for them this integrative, ecologically based philosophy is nothing new. There are others who certainly will see this as a philosophical elaboration or extension of concepts underlying the PRECEDE/PROCEED Model,[25] specifically the diagnostic portion of that model. The behavioral focus of this philosophy, contrary to what might seem somewhat intuitive, is not at all common in school health education today and does not appear to be the course promoted for its future direction.[4,16,17]

Recent literature suggests that school health education is in the midst of a "paradigm shift" and moving away from a philosophy based on knowledge development to one focusing on skills development.[4,30,31,32] Skills development is important for the development of health literacy and should be assessed as part of determining program impact. However, as the philosophical orientation for school health

education, skills development alone is too narrow and proponents of this approach often seem to confuse the development of skills with "real-life" behavior. This approach seems to lack a commitment to actually influencing the out-of-class behavior of children. The focus on skills development is laudable, but it is difficult to believe that health educators or parents would view a program as successful if students gained skills, but were still involved with health- threatening behaviors. If skills were really at the core of societal concern over health problems of youth, there would be no national debate about abstinence versus comprehensive sex education programs; HIV/AIDS education programs would not be trying to convince young people to abstain from sexual activity or use condoms; and programs would not have been developed to prevent violence and bullying. From a political and parental perspective, a philosophy that would be satisfied with skills outcomes in the absence of application and behavior would make program justification very difficult. To believe otherwise seems to deny reality.

A behaviorally focused, ecologically grounded, integrated philosophy is more consistent with student needs, societal interests and health education's long-term goals. Additionally, it focuses directly on health-related behavior, which traditionally has been, and often still is, the justification for including health education in school programs. If there are doubts about the relationship between present-day health education and concerns about health-related behavior, consider how the course of health education has been impacted by adolescent behavior related to alcohol, tobacco and other drugs; teen pregnancy; HIV/AIDS; and violence. Further evidence of this important connection can be observed in the CDC Risk Behaviors,[21] *Healthy People 2010*,[8] the National Health Education Standards,[16] and *Health is Academic*.[33]

Why examine school health education philosophy now?

American education is in the midst of a reform movement that is placing significant pressure on school health education programming. While the health education needs of children are well documented and deemed to be important, the need to improve "academic" performance has become the highest educational priority and is sweeping aside almost all other aspects of schooling. Areas outside of the "3Rs" are often viewed as competing for valuable school time and limited resources. Such "non-testing" areas, which include health education, are often perceived as barriers to gaining more time for the 3Rs, remediation programs and various activities related to preparing students for tests.

It is very difficult to refute arguments aimed at reducing or eliminating health education programming and to explain its importance related to educational reform when school health educators are unclear about their philosophy and goals. Since it is almost certain that health education programs will face increasing pressure to justify their existence as a result of the narrow focus of educational reform, it is imperative that school health educators be able to describe what they are trying to accomplish in a clear, defensible, and logical manner. A school health education philosophy must reflect a full understanding of schools and the reform movement, the needs of children, and the real problems being faced by health education today. The philosophy also must provide a foundation upon which to develop a justification for the class time that would be devoted to health education, must be viewed as appropriate by parents, and must be consistent with the goals espoused by the community and state.

Although it may be viewed by some health educators as reasonable and intellectually appropriate for the profession to "agree to disagree," this position provides no guidance for the school-based practitioners who are trying to explain and defend their programs. Such a position provides no assistance in helping practitioners articulate the relationship between what they are doing in class, the health problems of children and the health needs of society. Simply put, it is crucial that school health education have an operating philosophy that clearly identifies program goals or a hierarchy of goals. In addition, the philosophy must be reasonable, defensible, and help to unify its practitioners.

CONCLUSION

The proposed ecological/integrated behavioral philosophy draws from a variety of sources. As noted above, Hoyman,[22,23,24] O'Rourke,[6] Minkler,[10,11] Green and Kreuter,[25,34] and a variety of other authors have addressed various aspects of this approach to health education. Clearly, its components are not really new to the field. What is different is an attempt to draw the components together into an integrated school health education philosophy.

What is being proposed is certainly at variance with current trends in school health education practice. The skills-based philosophy is being promoted as an appropriate guiding framework for school health education practitioners and curriculum coordinators, despite examples in the literature of school programs in specific content areas, research projects, and school-based initiatives that focus on behavioral outcomes. Moreover, much of the behavioral-focused discussion in the literature is of a categorical nature rather than emerging from an overarching philosophical orientation. The behavioral philosophy espoused in this paper is not consistent with the skills-based movement, but does not necessarily contradict or disagree with programs emphasizing skills development, because skills are important in applying knowledge and can be precursors to health-related behavior. At issue is what school health education publicly and universally acknowledges to be its philosophical purpose and goal. The viewpoint of this paper is that the goal of school health education should not end with skills development, knowledge acquisition, personal disposition modification or environmental change. Rather, these elements should be viewed as important precursors to behavior and as significant contributors to the goal of students adopting a health-promoting *lifestyle*. At the same

time, it needs to be understood that a health-promoting lifestyle is not an end in itself, but rather a step toward improving or maintaining health and promoting an enhanced quality of life.

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