Health Promotion Theory: A Critique With a Focus on Use in Adolescents

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Note: The 5th edition of the APA manual was used.

“On my honor as a student, I have neither given nor received aid on this assignment.”

-Jackie Ripollone
Abstract

Health promotion is but one of the primary objectives in modern nursing. Health promoting behaviors can lead to a patient’s overall sense of well-being as well as protection from disease and chronic illnesses. Pender’s health promotion theory offers a holistic view of the patient, assessing the patient’s background and self-perceptions to allow the nurse to intervene and construct a plan accordingly. The health promotion theory can ideally be applied to all populations but is especially important in the adolescent population since they are at a critical time in their life for making independent health care decisions. A thorough critique of this theory indicates that this model can be useful in the adolescent population but may need to be adapted in various ways to be successful. It can also be concluded that many more studies need to be done applying this model to the adolescent population.
Introduction

With healthcare costs rising, health promotion has been of increasing interest not only to health care workers, but to the general public. Public attention to a positive state of health began escalating in the late 1980s (Pender, 1996) and a variety of “wellness programs” began developing as a result (Galloway, 2003). An important point is that health promotion is not just about disease prevention. Health promotion describes behaviors an individual can perform to bring greater longevity and a high quality of life. Health promotion can bring about a sense of wellbeing and harmony to the individual, can increase energy, and can also decrease social problems including violence and suicide (Peterson & Bredow, 2009). Adolescence can be an important time for intervention and encouragement of health promotion. Adolescents are unique in that they are not completely independent in their health choices and are much more vulnerable to both negative, and positive environmental influences (Srof & Velsor-Friederich, 2006). Therefore it is critical that health promotion be fully explored in this population. Nola Pender’s Health Promotion Theory is one of the most frequently used models for health promotion in adolescents (Montgomery, 2002).

Theory Description

Purpose

Nola Pender’s Health Promotion Model (HPM) was created to serve as a “multivariate paradigm for explaining and predicting health promoting component of lifestyle” (Pender, 1990, p.326). The model is used to assess an individual’s background and perceived perceptions of self among other factors to predict health behaviors. Before the HPM was published, another similar model had been developed which also took into account these factors to predict health behaviors. This model, the Health Belief Model (HBM), centered on the idea that fear or threat
of disease is the predictor for positive health behaviors (Peterson & Bredow, 2009). Studies support the HBM as being a disease avoidance model (Galloway, 2003).

Pender however, wanted to define health as not just being free of disease. Her definition of health includes measures taken to promote good health and includes the patient’s own view of themselves and their lifestyle (Peterson & Bredow, 2009). Taking into account her expanded view of health, she first published the HPM in 1982. In response to a particular study using her model, she then revised it in 1996 (Pender, 1996; Peterson & Bredow, 2009).

Pender’s model is meant to be a “guide for exploration of the complex biopsychosocial processes that motivate individuals to engage in behaviors directed toward the enhancement of health” (Pender, 1996, p. 51). Pender created this model to be “applicable to any health behavior in which ‘threat’ is not proposed as a major source of motivation for the behavior” (Pender, 1996, p. 53). Since the model does not rely on potential threat of disease as a source of motivation, it can be applicable in many more situations across the lifespan (Pender, 1996). This and the fact that the model addresses resources, which adolescents may lack, make it especially useful for use in adolescents (Montgomery, 2002).

Concepts

Two theories underlie Pender’s model which are important for understanding the concepts she describes. These two theories are the expectancy-value theory and the social cognitive theory. The expectancy-value theory is based on the idea that the course of action will likely lead to the desired outcome, and that this outcome will be of positive personal value (Pender, 1996). The social cognitive theory describes the concept of perceived self-efficacy which is “a judgment of one’s ability to carry out a particular course of action” (Pender, 1996, p.
Pender predicts that a high confidence level will lead to greater likelihood that the behavior will be performed.

There are three major concepts in Pender’s model which are further subdivided into narrower, more specific concepts. The major concepts are individual characteristics and experiences, behavior-specific cognitions and affect, and behavioral outcome. Each concept in the model applies to a specific area of patient assessment or action. One concept that was included in the HBM that has been purposely left out of the HPM is perceived threat of disease. By not including this factor as a determinant towards behavior the HPM focuses more on health promotion and less on illness prevention as the HBM aims to do (Pender, Walker, Sechrist & Stromborg, 1990).

Definitions

Before the definitions of HPM can be fully understood, it is important to reiterate Pender’s definition of health which serves as a basis for the entire model. She states that “Health is the actualization of inherent and acquired human potential through goal-directed behavior, competent self-care, and satisfying relationships with others while adjustments are made as needed to maintain structural integrity and harmony with relevant environments” (Pender, 2006, p. 22). Pender also offers a classification of behavioral expressions of health divided by affects, attitudes, activities, aspirations and accomplishments. It is important to note that her definition offers a holistic view of the individual and does not just focus on their illness (Peterson & Bredow, 2009).

Pender fully defines each of the concepts mentioned above in her book, *Health Promotion in Nursing Practice*. Personal factors are broken down in the model to biological, psychological, and sociocultural making it clear which personal factors are being considered. It
can also be inferred that Pender is breaking down the overall “environment” into what she defines as interpersonal influences (family, peers, and providers) and situational influences.

**Relationships**

Pender’s model identifies many relationships between concepts. Health promoting behavior is identified as the ultimate outcome of the model. Personal factors are independent variables that directly influence behavior-specific cognitions and also directly influence the specific health promoting behavior. Perceptions of self and influences on the individual directly influence commitment to a plan of action which then leads to the health promoting behavior. Health promoting behaviors are also both indirectly and directly influenced by prior related behaviors, and directly influenced by intermediate competing demands (Pender, 1996).

**Structure**

The model links the three major concepts in a general linear fashion towards the overall goal of the health promoting behavior. The diagram itself is also structured in a way that the key concepts are clearly organized under the three headings: individual characteristics and experiences, behavior-specific cognitions and affect, and behavioral outcome.

**Assumptions**

Pender (1996) outlines specific assumptions her model is based on which overall emphasize the fact that the patient has an active role in their health behavior. It is assumed that a patient can self-reflect, actively seek to regulate behavior, and initiate behaviors that modify their environment. Another assumption is that health professionals exert an interpersonal influence on an individual throughout their life (Pender, 1996).

**Internal Criticism**

**Adequacy**
The HPM adequately pulls together all of the factors that can motivate an individual to improve their health. Studies have shown that perceived self-efficacy, benefits, and barriers all play a role in predicting health behaviors (Pender, 1996). Srof & Velsor-Friedrich’s (2006) analysis of the model also indicates that self-efficacy and the behavior specific cognitions are supported as a predictive variable in multiple studies. This in turn supports Pender’s model as an adequate predictor of health behavior since self-efficacy is a central theme in her model. One weakness in the theory is that the model may not be completely accurate in use for communities and families as a whole since the focus is on an individual (Peterson & Bredow, 2009). According to Srof & Velsor-Friedrich (2006), the model may not be adequate for adolescents because of differences between adolescents and adults in independent decision making.

**Clarity**

The model is easily understood and the key concepts are clear. The definitions of the concepts are in an uncomplicated language and are understood by all health professionals. Her diagram clearly represents the relationships between the many factors involved in the patient’s behaviors and affects, and the outcomes/goals of health promotion. Although Pender has defined the difference between health promotion and health protection by eliminating threat of disease from her model, Peterson & Bredow (2009) point out that this may not always be easily distinguished in practice. Certain behaviors may be seen as both health-promoting and protection from disease. Threat of disease therefore may still be one motivation in certain health-promoting behaviors and it is unclear how this affects Pender’s model (Peterson & Bredow, 2009). Although one of Pender’s assumptions is that the health care provider can intervene in an individual’s behaviors towards health promotion, it is unclear at which point(s) on the model the provider should intervene.
Consistency

The terminology and definitions are consistent throughout the model with the health promoting behavior being the end goal. Each of the other concepts in the model either directly, or indirectly lead to this end point so that although there are many relationships between concepts, the overall goal remains clear.

Logical development

The model is already supported by Feather’s Expectancy Value Theory and Bandura’s Social Cognitive Theory which are well-established and provide the foundation for the model itself (Peterson & Bredow, 2006). Pender based her model on the HBM and “successfully addressed many of its criticism” (Montgomery, 2002). Pender’s argument for removing threat from her model is also a logical step in acknowledging the modern definition of good health used by all health care providers as not being simply “disease-free”. It is also important to mention that Pender addressed results of studies using her model, and revised it to be more applicable to all populations (Peterson & Bredow, 2009).

Level of theory development

The HPM represents a middle range theory because it describes a specific phenomenon in healthcare practice with a concrete end goal. It also has been refined to focus on 10 determinants of behavior that can be assessed for each patient (Pender, 1996). This makes the theory less abstract than a grand theory and specific enough to use for research and healthcare settings.

External criticism

Complexity

The model is limited to 11 key, clearly defined, concepts which keeps it from becoming too cluttered and complex. There are many relationships between each concept, many of them
both directly and indirectly affecting the ultimate endpoint of health promoting behavior. The overall framework however is linear, and it is easy to distinguish the progression from personal backgrounds to cognitions and affect and finally to health promoting behavior. One possible weakness however in this linear approach is that it does not incorporate reciprocal relationships Bandura (creator of the social cognitive theory on which the HPM is founded) describes in his work (Srof & Velsor-Friedrich, 2006).

Discrimination

Health promotion is a unique role of nurses but it does have similarities with other models such as the HBM discussed previously. Galloway (2003) puts forth other theoretical models that describe health promotion including the Transtheoretical Model (TTM) and the Theory of Reasoned Action (TRA). The TTM however focuses mostly on the process of change and less on the factors that influence it. The TRA focuses more on behavioral intent and their attitudes towards performing a certain behavior. One study analyzed by Srof & Velsor-Friedrich (2006) used an approach combining the HPM with the TTM in adolescents. The study concluded that both models used together may have been more adequate at predicting dietary behaviors in adolescents than either model used alone (Srof & Velsor-Friedrich, 2006). It is clear that more work needs to be done in testing the HPM in different populations.

Although similarities to these other models exist, in general the HPM is unique in that it distinguishes itself from other models by not counting threats or avoidance as a motivator for health promotion (Peterson & Bredow, 2009).

Reality Convergence

Not only are the concepts in the HPM well known to the health care field, health promotion has captured the attention of the general public as well. A particular concern in
America is rising obesity in children and adolescents leaving them at risk for cardiovascular disease, type II diabetes, and premature morbidity and mortality (Brown, 2008). This signifies a need for health promotion education for adolescents and their care providers.

**Pragmatic**

Peterson & Bredow (2009) state: “Although the model identifies foci for nursing interventions, it does not explicitly describe how nurses can effect changes in client perceptions” (p. 296). They are correct in that the model itself does not do this, but Pender’s book describes specific interventions to tailor plans to their patients including, reinforcing and identifying strengths in the individual, reiterating benefits of change, and identifying and setting specific goals. Pender also discusses using contracts with the nurse or “self-contracts” so the patient can be independent in rewarding themselves when they choose certain actions. In this case the patient “serves as the source of rewards” instead of the nurse allowing the patient to be self-sufficient (Pender, 1996).

The model does not outline specific ways to assess the patient to determine likelihood of action towards a behavior, but many instruments have been developed to do this using the HPM as a basis. Most of these, including the Health Promoting Lifestyles Profile (HPLP) that Pender recommends, are intended for adults rather than adolescents (Galloway, 2003). The HPLP is a 52 point questionnaire. This can be a problem in the adolescent population because of the comprehension needed and possibly large amounts of time needed to fill the questionnaire out accurately (Galloway, 2003). Pender does mention other instruments more appropriate to use for adolescents including Ryan-Wegner’s Schoolager’s Coping Strategies Inventory which measures stress-coping strategies, the Adolescent Life Change Scale, and the Adolescent Perceived Events Scale (Pender, 1996).
Scope

The scope of the theory is limited to predicting and identifying health promoting behaviors without including disease avoidance as a motivator for health behavior. The model does not limit itself to a specific type of health behavior performed, and therefore can be applied in a broad sense to many different settings. Pender (1996) discusses many different settings the theory can be used in including the workplace, schools, and hospitals but also in a broader scale including health promotion within families and in the community. Pender also outlines specific strategies in her book for constructing plans for individuals for health promotion. Specifics include nutrition information for individuals of all ages, exercise programs, and stress management.

Utility

The model is very useful in that it takes into account each individual’s behavior and preferences. This allows the nurse to develop a unique care plan that takes these behaviors into account.

Pender (1996) recommends using the nursing process including using nursing diagnoses and model-based assessments such as the Health Promoting Lifestyles Profile II. She outlines a multi-step process in developing a plan of care based on client’s strengths and preferences. Peterson & Bredow (2009) draw from various studies to note that “tailoring interventions has been found to increase intervention effectiveness” (p. 297). Many other studies have also proved useful in explaining variances in behavior in health promotion (Peterson & Bredow, 2009).

The HPM has been also adapted to be more useful in adolescents. Brown (2009) reviews studies that have used the Physical Activity Lifestyle Model (or PALM) which is similar to the HPM but has been more useful in the needs of adolescents. Although many studies exist using
the HPM in adults, Srof & Velsor-Friedrich (2006) state that “little work has been done to apply and explore the HPM in relation to the adolescent population” (p. 366).

**Significance**

Peterson & Bredow (2009) accurately note that this model has changed the focus of the role of the nurse from simply disease prevention to health promotion. Pender’s model is useful to the nurse because it helps expand their role to promote good health as opposed to just decreasing their risk for becoming ill. The nurse’s goals are now aimed at “strengthening resources, potentials, and capabilities” for each patient and providing resources and education to promote improved health and a better quality of life (Peterson & Bredow, 2009, p. 292). Not only does the model expand the role of the nurse, by focusing on self-efficacy, it also puts the patient’s health in their hands, allowing them to be agents of change. This model allows the patient and the nurse to work together towards a goal of a better quality of life.
References

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