Empowering health education : a conceptual framework and an instrument for assessing health professionals' use of empowering strategies
by Lynn Carol Paul

A thesis submitted in partial fulfillment of the requirements for the degree of Doctor of Education
Montana State University


Abstract:
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This research project occurred in two phases. The first phase entailed developing a theoretical basis for empowering health education that resulted in a set of eight principles representing the concept. Six adult education experts and seven health education experts critiqued this theoretical framework to establish the initial phases of construct and content validity of a health education empowerment construct. The second phase involved developing, piloting, and field testing an instrument assessing health professionals' use of empowerment strategies. The strategies for the instrument were developed from operationalizing the eight principles. Each principle and the strategies operationalizing each principle were sent to four of the seven health education experts used in the initial process of establishing validity. The experts then established content validity of the instrument and designated the items within the principle which fully operationalized the content of the principle.

Pilot and field test results indicated that Health Education Strategies Scale (HESS) possesses the initial qualifications of a reliable and valid instrument. Reliability, measured by the Cronbach alpha, was .91 for the 43-item HESS. The Pearson correlations for the final 43-item HESS for the item score to total score ranged from .17 to .77. The Pearson correlations for the item score to principle score ranged from .34 to .79.

# EMPOWERING HEALTH EDUCATION: A CONCEPTUAL FRAMEWORK AND AN INSTRUMENT FOR ASSESSING HEALTH PROFESSIONALS' USE OF EMPOWERING STRATEGIES

by

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A thesis submitted in partial fulfillment
of the requirements for the degree

of

Doctor of Education

MONTANA STATE UNIVERSITY
Bozeman, Montana

November 1992

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# ACKNOWLEDGEMENTS

The author wishes to express her gratitude to Dr. Robert Fellenz, chair of her committee, for his support and interest in empowerment; and appreciation to committee members Dr. Gary Conti and Dr. Clarann Weinert for their advice and assistance. The author values the contributions of her entire committee and the members of the national jury of experts.

A special note of thanks to her friends and family for their support and encouragement.

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# ABSTRACT

The empowerment model of health education has the potential to emerge as a useful model in the field of health education. For health care professionals to fully embrace the concepts of empowerment, they need to understand the philosophy of empowerment and their personal orientation toward that philosophy. The purpose of this study was two-fold: first, development of a theoretical basis for an empowering approach to health education and, second, development of an instrument for health professionals that will identify their predominant health education style as it relates to an empowerment approach.

This research project occurred in two phases. The first phase entailed developing a theoretical basis for empowering health education that resulted in a set of eight principles representing the concept. Six adult education experts and seven health education experts critiqued this theoretical framework to establish the initial phases of construct and content validity of a health education empowerment construct. The second phase involved developing, piloting, and field testing an instrument assessing health professionals' use of empowerment strategies. The strategies for the instrument were developed from operationalizing the eight principles. Each principle and the strategies operationalizing each principle were sent to four of the seven health education experts used in the initial process of establishing validity. The experts then established content validity of the instrument and designated the items within the principle which fully operationalized the content of the principle.

Pilot and field test results indicated that Health Education Strategies Scale (HESS) possesses the initial qualifications of a reliable and valid instrument. Reliability, measured by the Cronbach alpha, was .91 for the 43-item HESS. The Pearson correlations for the final 43-item HESS for the item score to total score ranged from .17 to .77. The Pearson correlations for the item score to principle score ranged from .34 to .79.

# CHAPTER 1

## INTRODUCTION

Within the past two decades, social and political forces have changed the concept of health from "an absence of disease" to "a general sense of well being and self-realization (Smith, 1981). Health educators need to respond to this changing nature of health by redefining the philosophy, principles, and methods of health education. The traditional or paternalistic model of health education, which developed with the "absence of disease" concept of health, prescribes that health care professionals assume power in the helping relationship and the patients remain passive. This dictates a didactic or information-giving format for health education in which patients are expected to comply in order to get well. This model of health education has not been effective in preventing and treating many of today's health problems that are the result of an array of complex individual, social, economic, and political influences (Marsick & Smedley, 1989).

Currently, health education is operating without a clear and sound philosophical background; therefore, health professionals are caught between the problems associated with the paternalistic methods and the absence of a solid health education theory, which inhibits provision of effective health education and the advancement of health education (Timmreck, Cole, James, & Butterworth,

1987). To operationalize programs and methods, health education needs an effective theoretical base.

The concept of empowerment has been suggested as a philosophical base for a broad range of human services. Empowerment is defined as "the ability of people to manage their lives, to recognize and meet their needs, and to fulfill their potential as creative, responsible and productive members of society" (Cohen, 1981, p. 514).

Empowerment has received serious consideration from leaders in the fields of community psychology, child welfare, social work, and rehabilitation (Dunst, Trivette, Davis, & Cornwell, 1988; Rappaport, 1987). The health field has also explored the philosophy of empowerment, particularly in areas where the traditional paternalistic model has been ineffective in dealing with the magnitude and complexity of the physical, social, and spiritual needs of patients. For example, select programs dealing with women's health, diabetes, and the AIDS epidemic have successfully adopted the empowerment approach (Anderson, Funnell, Barr, Dedrick, & Davis, 1992; Clement, 1987; Gutterman, 1990; Haney, 1988; Steinbaum, 1990; Stromquist, 1988).

Current trends in health education suggest both the need for and applicability of the empowerment philosophy for advancing the theoretical basis of health education. These trends include client responsibility popularized by the wellness movement and the self-help movement. The self-help movement, the fastest growing segment of health education in the past decade, maintains the

capacity of individuals and groups to create their own knowledge and address society's impact on health. The current health care scenario is in need of a change, but a change which considers the generative roles of the individuals, society, and the health care system in health status. Belief in the human ability to promote change at the individual, community, and societal levels is crucial (Hibbard, 1984).

Health professionals' responses toward empowerment depend upon their own knowledge and beliefs about the empowerment philosophy. If health professionals are to promote empowerment within their clients, for themselves, and within society, professionals need to be aware of their orientation to the empowerment philosophy and know what strategies promote empowerment (Ashcroft, 1987; Clark, 1989).

## Problem Statement

The empowerment model of health education has the potential to emerge as a useful model in the field of health education. For health care professionals to fully embrace the concepts of empowerment, they need to understand the philosophy of empowerment and their personal orientation toward that philosophy. Currently, there is a scarcity of information published presenting a theoretical background for empowering health education, and no inventories available to assist health care professionals to assess their orientation toward the use of empowerment strategies. The purpose of this study was two-fold: first, it developed a theoretical basis for an empowering approach to health education, and, second, it developed an

instrument for health professionals that will identify their predominant health education style as it relates toward an empowerment approach.

The following research questions were addressed in the process of completing the two-fold purpose:

1. What theoretical construct can delineate empowering health education and serve as a basis for developing behavioral strategies operationalizing empowering health education?
2. What are the strategies or behaviors used by health professionals that exhibit the theoretical construct of empowering health, and of these strategies which represent the construct?
3. What type of instrument would best assist health professionals' appraisal of their own use of empowering health education strategies?
4. Can a reliable and valid instrument be developed for health professionals to evaluate their use of empowering health education strategies?

## Significance of the Study

The development of a theoretical framework for empowering health education has the potential to provide a basis for theory development and a wide variety of quantitative and qualitative research efforts studying health education consumers, health professionals, social systems influencing health, and health care programs. Examining empowering health education will provide a broader and more in-depth understanding of the general concept of empowerment as well as

assist in the application of the empowerment philosophy in other fields that have been slow to explore the empowerment concept.

Application of research results has the potential to create empowering environments conducive to healthy lives for all and as a result to alleviate the problems associated with the current methods of health education. Ideally, this research will have the potential to move the focus of health education away from the generally ineffective, individualistic, paternalistic model toward health-promoting environments where people can more realistically assign responsibility for health problems and consequently more effectively deal with the actual causes of health problems. As a result of the instrument development, future research will be able to assess the progress achieved by health professionals through training and continuing education in acquiring the skills, knowledge, and strategies that promote empowerment.

## Assumptions

This study is based on the following assumptions:

1. The health of individuals is influenced by a wide range of physical, psychological, spiritual, social, political, and economic factors.
2. Because current approaches to health education are commonly paternalistic, individualistic, and generally limited in their success, the effectiveness of health education can be improved.

3. All those involved in creating health-promoting environments such as health professionals, health education consumers, community members, and policy-makers can learn how to adopt the empowerment approach.
4. Ultimately, empowering health-related environments will benefit all involved with creating and participating in these environments.

## Delimitations

1. Data for the instrument were collected from a small sample of professionals (N = 64).
2. The sample of professionals completing the pilot and field test were all from Montana.
3. The professionals completing the instrument were volunteers who filled out the instrument either in their workplace or while attending a professional conference.

## Definitions of Terms

Health behaviors include "those personal attributes such as beliefs, expectations, motives, values, perceptions, and other cognitive elements; personality characteristics, including affective, and emotional states and traits; and overt behavior patterns, actions and habits that relate to health maintenance, to health restoration, and to health improvement" (Gochman, 1990, p.14).

Health education is any action that addresses the many varied factors influencing health in order to ensure the environment is conducive to health (Tones, 1986).

Paternalistic health education approaches use didactic teaching methods and place professionals in expert roles.

Individualistic approaches to health education assume individuals can profoundly influence their health through appropriate health behavior, while ignoring the influences from the environment and social context.

Empowering health education is the development and enhancement of individuals, as well as their involvement and influence within communities and systems to improve their health status. It is an approach that can be applied to individuals, community organizations, workplaces, and neighborhoods (Rappaport, 1987). Empowering health education approaches acknowledge and address the many factors influencing health, such as the social, individual, political, and economic factors. Health professionals can play a significant role in empowering health education; however, consumers can initiate and participate in empowering health education without health professionals' involvement. Nonetheless, since the purpose of this study is to examine health professionals' involvement with empowering health education, empowering health education will usually refer to health education where health professionals play a significant role.

Instruments can be used to study samples from populations "to discover the relative incidence, distribution, and interrelations of sociological and psychological variables" (Kerlinger, 1986, p. 377).

## Dissertation Organization

This dissertation is organized into six chapters. Chapter 1 has provided a brief introduction to the current status of health education, the concept of empowerment, and the potential for improving consumers' health status by adopting empowering health education. The content of Chapter 1 also presents the problem statement, research questions, scope of study, significance of the study, assumptions of the study, delimitations of the study, and definitions of terms.

The literature review for this study is found in Chapter 2. The major areas covered in this chapter include the origins of empowering education and the current philosophical status of empowering education. Chapter 2 also examines empowerment in practice, exploring synthesis, critique, and research findings, and finally empowerment as it directly related to the current status and trends of health education, including the role of health professionals.

Chapter 3 details the methodology used in developing the theoretical basis of empowering health education and the instrument for health professionals. Chapter 4 and 5 provide the results of the research; Chapter 4 covers the results of the theoretical basis and Chapter 5 provides analysis of the instrument to include

results of item analysis, reliability, and validity. Finally, Chapter 6 presents the conclusions of the study and recommendations for practice and research.

# CHAPTER 2

# LITERATURE REVIEW

A review of empowering health education requires examination of two aspects of empowering health education. The first is an examination of the general concept of empowerment which explores the origins of empowering education, the current theoretical framework, empowerment in practice: synthesis, critique, and research findings. The second is a review of empowerment as it directly relates to health education. This includes the current status and trends of health education and the involvement of health professionals.

## Review of the General Concept of Empowerment

### Origins of Empowering Education

A major figure influencing the conceptualization of the empowerment concept and its current applications is Paulo Freire. Freire's educational interests centered on literacy efforts among the poor in Latin America beginning in the late 1950's. Freire believed literacy would help alleviate the problems of the poor, which were problems imposed upon the impoverished by political oppression from the upper class (Freire, 1970a).

Paulo Freire believed that a political environment producing oppression was not a fixed reality, but rather that it is a problem that could be alleviated through the collective efforts of the oppressed people. Freire felt the education system was one means through which the upper class disempowered the poor; however, through a different type of education, the poor could be liberated by gaining the power, skills, and confidence they needed to transform society so all could live with human dignity. He maintained liberation should be achieved through education. The goal then of education was liberation. However, Freire recognized that education could never be politically neutral; education either supported liberation or oppression (Freire, 1970a).

In order to achieve liberation through education, the educational system needed to be empowering. According to Freire, empowering education involves oppressed groups collectively identifying their own problems, critically examining the social roots of the problem, strengthening hope and envisioning a better life, and then organizing to achieve their goals by overcoming social and political barriers. Through such group participation and growth, people realize their abilities to change their lives on a personal and social scale. Thus, empowering education can potentially influence people at many levels from developing personal skills to individually and collectively creating social reform (Freire, 1970a, 1970c; Shor & Freire, 1987).

Empowering education is in direct contrast to the traditional, disempowering educational approach described by Freire as "banking" education. Banking

education is both paternalistic and individualistic in nature since it treats knowledge as a gift bestowed by those who are knowledgeable to those who do not know. This paternalistic approach views teachers as experts who exclusively possess the knowledge of the topic. Student are viewed as objects who are passive, empty receptacles which teachers fill with knowledge. The transfer of knowledge usually occurs in a static exchange with little discussion. Banking education is individualistic in nature because it seldom recognizes students' uniquenesses in terms of their personal characteristics and rich context of living. Banking education can also be seen as individualistic because it frequently ignores political, cultural, economic, and social influences on students' lives and how these influences impact their learning (Fahlberg, Poulin, Girdano, & Dusek, 1991; Freire, 1970c; Shor & Freire, 1987).

Rather than using the disempowering banking educational approach, Freire thought empowering education should occur through four methods: critical consciousness, critical thought, dialogue, and praxis. Critical consciousness is a process of naming the world or recreating reality and then working through political participation to achieve humane existence. According to Freire, critical thought is the ability to form and express complex and realistic judgements about one's world. He believes that everyone regardless of education and social class is capable of viewing the world critically. Oppressed people make naive judgements about their world because of their oppressed conditions. The ability to think critically allows oppressed people to view their current situation as limiting but challenging rather

than to accept an unalterable and fatalistic view of their conditions. Once capable of critical thought, people can begin to challenge the structures in society that oppress them (Shor & Freire, 1987).

Critical thought is learned through dialogue. Dialogue is a problem-posing participatory format where knowledge about a problem or topic is recreated and social relations within the educational setting are transformed. In an educational environment, the teacher and students dialogue by mutually inquiring about the topic to be learned. Students and teachers figuratively put a topic on the table and collectively learn about the topic. The teacher relearns the topic through studying with the students. Not only are students empowered through dialogue, but the teacher or facilitator is empowered again. Dialogue demands dynamic communication and makes education a social activity (Shor & Freire, 1987).

Freire insists that authentic dialogue must lead to action, reflection, and further action: Freire named this action-reflection praxis. Praxis is critical in creating meaning and knowledge in the process of changing the oppressive political and social barriers, or transforming the world (Freire, 1970b).

Freire insists that critical consciousness, critical thought, dialogue, and praxis be viewed as skills necessary for achieving liberation and not as mere techniques used by teachers in oppressive educational settings for attaining results. These skills should be based within empowering educational settings with liberation as the goal (Shor & Freire, 1987).

Freire's contribution to empowerment has significantly expanded education's potential role in alleviating and preventing many problems associated with oppressive, paternalistic, and individualistic systems (Minkler & Cox, 1980; Parsons, Hernandez, & Jorgensen, 1988; Reisch, Wenocur, & Sherman, 1981; Wallerstein & Bernstein, 1988). The goal, philosophy and methods proposed by Freire provided an important and meaningful groundwork for the current trends in many areas adopting an empowerment approach.

## Current Philosophical Conceptual Basis of Empowerment

An understanding of the origins of empowerment provide a context for examining current philosophical frameworks of empowerment. As mentioned previously, the empowerment philosophy has been adopted by a wide range of groups and communities. Many of these groups and communities have modified Freire's original philosophy to meet a broad range of needs within their specific contexts. Often these groups selected certain components of Freire's empowerment concept while eschewing other components (Anderson et al., 1991; Clement, 1987). As a result of using select components to meet a range of needs in a variety of contexts, Freire's original concept of empowerment has been significantly altered.

Current uses and meanings of empowerment have not been well examined by theorists, researchers, or practitioners (Clark, 1989; Dunst, Trivette, & LaPointe, in press). The contextual nature of empowerment demands that empowerment receive critical analysis in the different contexts within which it is utilized (Clark,

1989). Using select components of empowerment or viewing empowering methods as skills to be acquired without the additional goal of social transformation can lead to a great disservice of the people to be empowered and perhaps further oppression. The concept of empowerment is more likely to be contaminated, especially by politically oppressive groups, without a current, well-examined philosophy of empowerment (Fahlberg et al., 1991; Zacharakis-Jutz, 1988). The lack of critical analysis impedes both the development of empowerment theory and praxis and the successful application of the approach.

Dunst et al. (in press) and Rappaport (1987) have contributed much to a critical analysis of the empowerment concept. Dunst et al. (in press) developed a unified framework of empowerment that enhances the understanding of the concept and helps define the key elements of the concept. The framework was proposed as a useful model in demonstrating the use of empowerment in everyday situations. The framework consists of three major features: form, level, and context. These features are organized into a three-dimensional matrix. The first feature, form, addressed the diverse operationalization, description, and practice of empowerment. Six diverse uses or forms of empowerment were identified: philosophy, paradigm, process, partnership, performance, and perceptions (Dunst et al., in press).

The second major feature of this empowerment framework is level of analysis. This second feature refers to "the focus of efforts to empower people" (Dunst et al., in press, p. 2). There are four identified levels or foci of empowering efforts: individuals, groups, organizations, and communities. This second feature of

the framework, level of analysis, provides an excellent organizational structure for examining how empowerment has been practiced and researched, which is addressed later in this chapter.

The third major feature of this empowerment framework is context, referring to the various environments or settings in which people may experience empowerment. An important assumption about empowerment is that empowerment will look different depending on the context within which it is used. Four types of contexts or systems are used in the framework: microsystems, mesosystems, exosystems, and macrosystems.

This unified framework consisting of three major features and categories within each feature yields a 96 cell three-dimensional matrix of the empowerment concept. By delineating every combination possible within the three features, this matrix greatly enhances the ability for clarity and exactness when discussing and researching empowerment. However, this framework may not allow for understanding the interaction among these components of empowerment (Dunst et al., in press).

Rappaport (1987) proposed an ecological theory of empowerment and defined the concept as "individual determination over one's life and democratic participation in the life of one's community, often through mediating structures" (p. 121). He suggested 11 assumptions and hypotheses as guidelines for theory and research:

1) Empowerment is a multilevel construct. It is concerned with the study of and relationships within and between levels of analysis--individuals, groups, organizations, and other settings, communities, and social policies. It is assumed that there is a mutual influence process across levels of analysis, and that this process takes place over time.

2) The radiating impact of one level of analysis on the others is assumed to be important.

3) The historical context in which a person, program, or a policy operates has an important influence on the outcomes of the program.

4) The cultural context matters.

5) Longitudinal research, or the study of people, organizations, and policies over time, is seen to be at least desirable, and perhaps necessary.

6) Empowerment theory is self-consciously a world view.

   a) The people of concern are to be treated as collaborators; and at the same time, the researcher may be thought of as a participant, legitimately involved with the people she is studying.

   b) The choice of our language is seen to be very important as to what it communicates, and metacommunicates, not only to other researchers and policy makers but also to the people who we are studying.

7) It is assumed that the conditions of participation in a setting will have an impact on the empowerment of the members.

8) Other things being equal, an organization that holds empowerment idealogy will be better at finding and developing resources than one with a helper-helpee ideology, where resources will be seen as relatively scarce, and dependent on professionals.

9) Locally developed solutions are more empowering than single-solutions applied in a general way.

10) The size of the setting matters. Settings that are small enough to provide meaningful roles for all members, yet large enough to obtain resources, are hypothesized as more likely to create the conditions that lead to empowerment.

11) Empowerment is not a scarce resource which gets used-up, but rather, once adopted as an ideology, empowerment tends to expand resources. (Rappaport, 1989, pp. 139-142)

Overall, the major contributions of Dunst et al. and Rappaport's critical analyses are very useful and important in promoting an examination of the empowerment concept. This researcher found Rappaport's eleven assumptions and hypotheses and Dunst's "level of analysis" concept or focus of efforts to be the most comprehensive, clear, and practical basis for understanding empowerment. Further development of the philosophical basis of empowerment is needed in order to fully understand empowerment and its implications for practice.

## Empowerment in Practice: Synthesis, Critique, and Research

The empowerment philosophy has been adopted in many situations with the focus of efforts ranging from individuals to social class (Wallerstein & Bernstein, 1988; Zimmerman, 1990). This section will review the attempts to operationalize empowerment in a wide variety of settings and professional fields and the critiques of these attempts. Additionally, this section will also review the few research studies that have been conducted on the empowerment construct. In general, such research has been scattered in scope, and as concluded in the previous section has lacked a unified framework or critical analysis for assessing research outcomes.

The organizational structure for this next section will follow Dunst's et al. (in press) "level of analysis" or focus of efforts, which was one of the three features in the unified framework of empowerment. Since focus of efforts feature is the starting point for professionals adopting the empowerment framework, it is useful for an analysis of practice-oriented empowerment. When a problem is recognized, the initial assumption, whether explicit or implicit, is the level or focus of efforts. Many times this is defined by the agency or organizational group initiating the use of the empowerment process. For those involved with Freire's approach, the oppressed social class is viewed as the focus of efforts or level of analysis (Wallerstein & Bernstein, 1988). However with the adaption of the empowerment philosophy, the focus of efforts has been greatly expanded based on the needs of the initiating group. As a result of the original assumptions of the level of analysis and empowerment concept, the units of change have been identified as individuals, families, communities, and social class. This next section will examine the empowerment approach within the four levels of analysis and the research findings within these levels.

Individual as Focus of Change. Those focusing on the individual as level of analysis frequently refer to empowerment as self-empowerment or personal empowerment. Self-empowerment has been defined as a "process by which individuals can increasingly take charge of themselves and their lives" (Bernard, 1988, p. 88). It frequently has been compared to and aligned with self-efficacy or

the belief in one's ability to be self-motivated and to meet situational demands (Kayman, 1989; Ozer & Bandura, 1990). Those emphasizing the individual as focus of efforts may not incorporate a social and political process as a critical element of their philosophy. A review of the literature suggests that the tie or link of personal empowerment with social action is not the norm (Anderson et al., 1991). It is not uncommon for programs to express a need for social change and then to focus solely on the individual component. For example, there are diabetes educators who have formally designated an empowerment approach as their educational philosophy and who express that they enable patients to make informed decisions about health care and to change the social situations and institutions that influence their lives, but then these diabetes educators focus entirely on the patient-professional relationship as a means of empowering clients (Anderson et al., 1991). Some human service professions, such as psychology, have adopted a view limited to self-empowerment without addressing social action because these fields have focused on individualism for several decades. If professions or agencies have historically focused on individual factors with little or no emphasis on social and political factors, the self-empowerment approach is a more likely choice than Freire's approach.

Limiting an empowerment approach to the development of individuals is questioned by theorists who maintain that true empowerment can only occur among disempowered groups and that relying upon the individual as the focus of efforts is

an inappropriate adaptation of the concept of empowerment. Freire expresses his opinion on this debate as follows:

> My fear in using the expression "empowerment" is that some people may think that such a practice simply empowers the students, and then everything is finished, our work is done, over! Even when you individually feel yourself most free, if this feeling is not a social feeling, if you are not able to use your recent freedom to help others to be free by transforming the totality of society, then you are exercising only an individualist attitude towards empowerment or freedom. Even though they can feel and perceive themselves after the semester as first-rate students, more critical students, better scientists and better people, it is still NOT enough for the transformation of society, this feeling of being free. While individual empowerment or the empowerment of some students, the feeling of being changed is not enough concerning the transformation of the whole society, it is absolutely necessary for the process of social transformation. The critical development of these students is absolutely fundamental for the radical transformation of society. Their curiosity, their critical perception of reality, is fundamental for social transformation but it is not enough by itself. (Shor & Freire, 1987, p. 22, 23)

As is evident from Freire's discourse, the goal of empowerment is social transformation, but empowerment does not disregard the personal development that must occur in the process.

Research in this empowerment approach indicated self-efficacy named "self-empowerment" was used as an instructional model for women attempting to reduce the amount of fat in their diet (Gorbach et al., 1990) and for women mastering the physical skills necessary for defending themselves against assaults (Ozer & Bandura, 1990). The results of these studies indicated participants perceived growth in coping skills and ability to achieve goals. Zimmerman's (1988) research investigated participation in volunteer organizations as a means of developing

personal empowerment and perceived sense of control over life's problems. He measured empowerment by cognitive, personality, and motivational indices. The results indicated that individuals with high levels of participation also experienced higher levels of personal empowerment.

Family as Focus of Change. Some social workers and others involved with child care have adopted the family as the level of analysis (Dunst & Trivette, 1987; Dunst, Trivette, & Deal, 1988). Not only is the family the primary unit to deliver care to children, but also the environment that has the greatest influence on child's development and health (Shelton, Jeppson, & Johnson, 1989). It is the family's ability to cope and to provide for the individuals within the family's environment that becomes the focus of the empowerment process. The goals of the empowerment process are to develop the family's strengths and abilities to cope. This process involves helping the family distinguish between external factors and factors over which the family has immediate control. The social setting is generally seen as a limited means of strengthening support and coping ability of families, rather than as a sphere for broad social transformation to eliminate the underlying conditions creating the problems. However, it is important to understand that there is little emphasis on directly influencing the broader political, social, economic factors affecting the family's health (Dunst & Trivette, 1987; Dunst, Trivette, & Deal, 1988; Shelton et al., 1989).

Research in empowerment using the family as focus of efforts has shown that professionals employing empowering strategies with families are more effective than those who employ a more paternalistic approach. Professionals using an empowering approach increase their effectiveness in assisting families to meet their needs and in providing opportunities for families to become more competent in managing their child's needs (Dunst, Trivette, Davis, & Cornwell, 1988; Weaver, 1982).

Community as Focus of Efforts. Many diverse communities have employed an empowerment process. Here communities are defined as a group of people with a common link or connection, such as a neighborhood or workplace. A group of people may also act as a community if an unresolved issue serves as a link for their interaction. For example, people involved with a controversial local environmental issue may form a community. Communities employing an empowering approach may be brought together by their own volition or organized by an agency to address a common problem that has been inadequately addressed by society's current systems. The goal of communities employing empowerment approaches is for the group to increase its control over factors influencing the members of the group and the broader community. Frequently, communities as focus of efforts influence a much broader range of social, political, and economic factors than the individual or family as level of analysis. In part, this broader range of influence occurs because of the greater, potentially powerful, outcomes of group processes and the fact that

many of these communities are initiated or framed outside traditional social institutions that have historically disempowered people (Dunst et al., in press).

Myles Horton, founder of the Highlander Research and Education Center, has been a prominent national influence for the past five decades in using empowering educational processes within communities. Horton and Highlander have worked with local people to enhance their abilities to actively participate in alleviating their problems. Highlander has been effective in empowering communities in dealing with labor movements, civil rights, and environmental protection (Adams, 1975).

Research involving the community as the level of analysis has been qualitative in nature. Freire's approach to empowerment has been the basis for the majority of these studies. A sampling of communities that have researched an empowering process includes community health groups in London, alcohol and abuse prevention programs for adolescents in New Mexico, rural health care in Honduras, nutrition education programs in Micronesia and the Dominican Republic, and environmental protection in the South (Adams, 1975; Kent, 1988; Kilian, 1988; Minkler & Cox, 1980; Rody, 1988; Wallerstein & Bernstein, 1988). The research findings indicated that using the empowerment approach resulted in participants better understanding their problems, and that it encouraged them to survey their own communities, plan more appropriate solutions or interventions than those created by the experts, and create new resources.

A particular type of research, participatory research, has been used with empowering communities. Participatory research intertwines research, education, and action and is a research process in which communities participate to promote the development of the community and social transformation. The community members are fully involved and in charge of the definition of the problem, the collection of data and information, and the analysis of the results. Nationally, participatory research with communities has examined community power structures, land use and reform, and "right to know" movements. For example, communities have researched the public's right to know about information that is typically the domain of corporations and the scientific and medical professionals such as toxic chemicals that are used in work or in communities (Gaventa, 1988; Gaventa & Horton, 1981).

Some studies have indicated the failure of an empowerment approach. Gruber and Trickett (1987) studied the participative decision-making of the governing body of an alternative public school in Connecticut. The intent of the governing body was to empower parents, students, and teachers, but the approach failed for two reasons. First, the process thought to increase participative decision-making actually created significantly unequal roles for the parents, students, and teachers. The teachers dominated the process because of their role in and knowledge of the educational system. Secondly, the overall ideology or philosophy of the school system did not allow for creating equality in the governing body necessary for participative decision-making. The researchers cautioned against

using one group with organizational power, such as teachers, within a bureaucratic context with overt inequalities to empower disempowered groups within the bureaucratic system (Gruber & Trickett, 1987).

Social Class as Focus of Efforts. Those who maintain Freire's interpretation of empowerment as the valid approach accept social class as the only true and viable level of analysis. Freire's conceptualization of empowerment places emphasis on the social aspect of change. The focus of efforts are groups of oppressed people who, through the processes of critical consciousness, critical thinking, dialogue, and praxis, transform their world. As a result of empowerment, the political and social structures that have been the root causes of disempowerment are eliminated and liberation can occur when people develop the skills and knowledge necessary for creating empowering environments (Freire, 1970a; Rody, 1988).

Many consider removing political and social structures and creating empowering environments vital because personal empowerment without an empowering environment that allows the individual to make empowering choices is a "mockery of empowerment" and, worse, an incredible disservice to the individual (Zacharakis-Jutz, 1988). "If we assume that the efforts to remediate individual and family problems can occur apart from the broader efforts to restructure the institutional context from which these problems emerge" (Reisch et al., 1981, p. 108), a disservice is created to individuals and families. In essence, those adopting the self-empowerment approach point out that this fostering of personal

environment without an empowering environment creates the ability to make choices when no real choice is available. Such ability to choose is meaningless unless there are changes occurring at the social and system levels (Reisch et al., 1981).

Another issue discussed by those espousing social transformation is the trend toward oppressive and bureaucratic organizations and systems within the societies adopting the empowerment philosophy. The feared result is creation of additional structures of oppression under the guise of empowerment (Zacharakis-Jutz, 1988).

Those who maintain that the only valid appropriate goal of empowerment is social transformation assume that focusing on another level of analysis, such as the individual, family, or community will not lead to social transformation. However, there is a significant group who believe otherwise. Their arguments propose that those skills gained through a self-empowerment approach will make a person more willing to be involved with community and social issues (Bernard, 1988; Fried, 1980). Rappaport (1987) expressed in his theory of empowerment the potential influence of one level of the empowerment construct on another level. The influence of one level on other levels of empowerment can be enhanced or assured if the processes of critical consciousness, critical thinking, dialogue, and praxis are employed. These processes will greatly increase the chance that those working on the individual level will grow to understand the impact and barriers of larger social and political factors.

Participatory research has been the primary research base for empowerment in social class. Participatory research is used by or for people who are exploited and oppressed by the dominant structures of society with the goal of social transformation. Nationally and internationally, participatory research has been employed by the women's movement, human rights, minority health, and many other issues. The people involved become more knowledgeable through their participation. They become aware of their situation and possible ways to change that situation (Tandon, 1981).

The review of literature indicated limited research in empowerment other than the participatory research contributions. The majority of studies have used qualitative research methods. Quantitative research methods have primarily targeted self-empowerment. The scarcity of research has been due in part to the lack of a unified framework and broad and multi-level constructs of the concept. By its nature, empowerment manifests itself differently in each unique context. This lends to difficulty in generalizing findings. The outcomes of the empowerment process also have not been adequately categorized. In fact, outcome indices were described in only two studies (Rody, 1988). In order for the empowerment concept to be effectively utilized in practice, the concept is in dire need of a unified framework and systematic research.

## Empowerment and Health Education

### Current Status of Health Education and Trends Toward Empowerment

The previous section examined empowerment in practice and research findings from a wide variety of fields, such as social work, public education, and psychology. In order to understand empowering health education, it is important to specifically examine empowerment as it relates to the current status of health education, future trends of health education, implications of empowering health education, and the professionals involved with health education. Currently, health education is immersed in two frameworks, individualism and paternalism (Fahlberg et al., 1991). Paternalism is reflected by a communication style which focuses on health professionals' ability to define and present solutions to the clients' health problems using the didactic approach. In this traditional approach, the time following the initial interaction with the health professional is characterized by clients' attempts to comply and adhere to the dictated prescription. The traditional paternalistic system assumes the health care power role resides with health care professionals, thereby creating a passive role for clients (Clement, 1987; Rody, 1988). In part, this imbalance in power has been accepted because the relationship has been seen as a helping one. Ultimately, however, the clients' lack of control and power negatively effects clients' psychological and physiological well-being (Arntson & Droge, 1988; Wallerstein & Bernstein, 1988). The individualistic

approach to health education focuses on the individual with little recognition given to the influence of the environment and social context (Fahlberg et al., 1991).

In the empowering approach, consumers share the power role with the health professionals. The professionals convey respect for consumers' capability of understanding and learning how to manage their health problems. This is primarily accomplished by using strategies that require consumers to make decisions. The empowering interaction is highly dynamic; through dialogue professionals and consumers share and create knowledge and reflect on perspectives and experiences. In the empowerment process, this time is seen as an opportunity for consumer's growth, discovery of knowledge and skills, and plans for action. When new competencies necessary for coping with health problems must be learned, they are most effectively learned in a context of life rather than solely during the interaction with health professionals (Dunst & Trivette, 1987; Dunst, Trivette, Davis, & Cornwell, 1988).

The focus of the individual experiencing empowering health education changes from well-informed, compliant behavior in the traditional model to a proactive stance of creating healthy environments for self and others. In the empowerment approach, health professionals have the opportunity to add to their rich and complex experiences and skills. The overall experience is enhancing for everyone, especially as health professionals and consumers, individually and collectively, affect society's systems (Parsons et al., 1988; Pinderhughes, 1983).

The Role of Health Professionals

Client dependence is often unknowingly initiated by professionals. Even when health professionals intend to foster independence within consumers, health professionals' choice of health education strategies may, in fact, develop dependence within consumers. Additionally, the traditional paternalistic health education approach assumes that professionals are socialized into believing that only they have the answers to solve clients' problems. "Taking control and filling in missing resources may seem expedient in terms of meeting the needs of children . . . but in the long run it deprives families of enabling experiences that will make them more competent and better able to understand and manage their children" (Dunst, Trivette, Davis & Cornwell, 1988, p. 79).

Dunst, Trivette, Davis, and Cornwell (1988) researched the effects of the relationships between human service providers and consumers using case studies to point out important processes that influence health care practices. They examined the help-giving attitudes and behaviors that lead to consumers' sense of control over life events and concluded "the findings clearly point to the fact that unless professional helpers employ help-giving styles that are both enabling and empowering, the chances of making positive impacts will be diminished considerably (p. 78). Additionally, research on professional education for diabetic educators investigated whether educators could gain the skills and attitudes necessary for using a patient empowerment approach. The results indicated that educators made significant gains in their counselling skills, attitudes, and perceptions. The greatest

difficulty for the educators was dealing with patients' emotional issues and allowing the patients to solve their own problems (Anderson et al., 1991).

Educating clients regarding their appropriate participation is a major challenge requiring development of a collaborative, democratic relationship between clients and health professionals (Spence, 1988). "Patients often give practitioners the right to define the problem, provide a solution, and even evaluate the solution's effectiveness" (Arntson & Droge, 1988, p. 2). When professionals assume the responsibility of dictating the patients' goals and problems, compliance and adherence become overriding issues in patient education (Goodwin-Johansson, 1988).

High quality, effective health education depends not only on the professionals' technical expertise but also on the effectiveness of their helping skills (Sanson-Fisher, Campbell, Redman, & Hennrikus, 1989). There is growing awareness of the impact on the client regarding the type of helping strategies used by health professionals. This has been noted whether patient outcomes are framed in the paternalistic model, such as noncompliance, or the empowerment model, such as dependence on the professional (Dunst, Trivette, Davis, & Cornwell, 1988; Glanz, 1979). Glanz (1979), operating from the paternalistic model, suggested that it is important to explore professionals' impact on promoting noncompliance. Similarly, Dunst, Trivette, Davis, and Cornwell (1988), proponents of the empowerment model, found that dependence on the health professional was often induced by certain health education practices.

Since helping strategies used by health professionals are dictated directly or indirectly by the professionals' philosophy of education (Rinke, 1986), it follows that the philosophy of health education will also direct the goals and objectives of health education (Smith, 1981). Because philosophy has a tremendous impact on education, it is crucial that professionals be conscious of and articulate their philosophy (Ashcroft, 1987; Clark, 1989; Cohen, 1981; Miller & Wolff, 1981). Once professionals are aware of their philosophy, they can then reflect on the value of their framework or frame and can consider alternate frameworks. "Reflecting on a frame is very different process than acting from a frame" (Ashcroft, 1987, p. 152).

Unfortunately, health care professionals have been slow to articulate their philosophy (Achterberg & Trenkner, 1990). Moreover, the theoretical underpinnings of health education have been described as underdeveloped (Timmreck et al., 1987). Moreover, Smith (1981) describes the state of health education philosophy as a collection of "seemingly unrelated, multiple, and ambiguous views" (Smith, 1981, p. 43).

To assist health professionals in understanding their philosophy of health education and realizing the goal of empowerment, health professionals need an awareness of self. Awareness of self can be promoted through reflection on their practice and self-assessment or self-evaluation. Reflection and self-assessment have been determined to be important in promoting change for health professionals in their attempts to develop alternative methods of helping strategies. In order to change helping strategies, professionals need a systematic method of self-awareness

and exploration. Self-awareness can be enhanced through the use of self-assessment methods (Ashcroft, 1987; Dunst, Trivette, Davis, & Cornwell, 1988; Marsick, 1988; Miller & Wolff, 1981; Yonemura, 1986). Thus the effort to create an effective instrument for self-evaluation can provide an important foundation for empowering health education.

If empowerment is to be employed, professional training should include knowledge and skills in educational methods that develop the clients' independence and coping skills. Professionals need to understand the issue of power and how it relates to professionals and the clients (Reisch et al., 1981). Without complete understanding, health professionals are likely to rely either upon the paternalistic or individualistic models--even if the idea of empowering health education is appealing to them. Appreciation of the general concept of empowerment and of the specific health education environment can facilitate the implementation of empowering strategies in health education.

# CHAPTER 3

# METHODOLOGY

This research project occurred in two phases. The first phase entailed developing a theoretical basis for empowering health education that resulted in a set of eight principles representing the concept. The second phase involved developing, piloting, and field testing an instrument assessing health professionals' use of empowerment strategies.

## Theoretical Framework

The primary purpose of the first research agenda was to fully explore and delineate the concept of empowering health education. Despite increasing attention to empowerment during the past two decades, the theoretical basis for the application of this concept to the health education field had not been adequately explored. It was therefore necessary to generate a clear conceptual basis for empowering health education. A theoretical framework was established that included a definition of empowering health education, a goal for achieving healthy lives based on using the empowerment approach, assumptions regarding human nature and the causes of health problems used in developing the principles and model, a set of principles defining the empowerment construct, and a model and

brief narrative describing the components and process of empowering health education (see Appendix A). An example of one assumption included in the theoretical framework was, "Health problems are the result of individual and societal conditions, especially the lack of opportunities for people to develop the necessary power, skills, and knowledge to create healthy lives." An extensive literature review in the areas of adult education, empowerment philosophy, and health education provided a foundation for this theoretical framework.

Six adult education experts and seven health education experts critiqued this theoretical framework to determine its accuracy and comprehensive representation of empowerment in health education practice and its relevancy to the field. The 13 experts were recognized professionals with advanced degrees in adult education or health and with established publication and presentation records in the area of empowerment. The adult education experts were selected from the membership list of the Commission of Professors of Adult Education and the health education experts were chosen based on their contributions to the research and practice of empowering health education. The health education experts also were chosen so that the group represented a variety of professional backgrounds. (See Appendix B for the listing of the 13 experts used in this research phase.)

The experts received the complete theoretical framework and a cover letter with instructions for completing their critique (see Appendix C). The general instructions outlined their role in establishing the initial phases of construct and content validity of a health education empowerment construct. The first step in the

critique was for the professionals to review and comment on the synopsis of empowering health education, the working definition of empowerment, the goal of empowerment, and the set of assumptions. Next, the experts were to critique each principle for its clarity and accuracy and then address whether the principles adequately and accurately represent the empowering approach to health education. Finally, the experts were instructed to comment whether the model reflected the principles and if the design of the model appropriately reflected empowering health education. Suggestions for clarification and improvements on any aspect of that validation process were also requested in the letter to the experts.

The comments from the 13 experts were assessed initially to determine the total content of the comments. These comments were then analyzed to determine if specific themes emerged either reinforcing ideas or identifying areas for change or addition. Finally, the comments addressing each component of the framework were assessed.

As a result of the experts' comments, the conceptual framework was revised; the set of principles validated by the experts replaced the model as the endpoint. This was due to three considerations. The first consideration was the experts' questions regarding of the adequacy of the model. The second factor was the difficulty of using the model to comprehensively describe the construct of empowering health education. Finally, major difficulties were encountered in generating a comprehensive list of behavioral strategies based on the model demanded further specification.

The total content of the comments as well as the emergent themes were used to revise the set of principles. Also each principle was critiqued to determine if the principle adequately represented the identified aspect of the empowering health education framework. The total organization of the principles was also assessed to determine if certain principles could be eliminated, condensed, changed in focus, or enhanced. A second review of the literature also assured that the principles adequately represented the construct. As a result of this thoughtful analysis of the experts' comments and second review of literature, the conceptual framework was refined.

## Instrument

This next section will detail the steps taken in the development of the instrument for health professionals to assess the use of empowering health education strategies. From this point on, the instrument will be referred to as HESS (Health Education Strategies Scale). The first step in the development of HESS was determining the format of the instrument. This was accomplished through a review of the instrumentation literature. A literature review and information provided by leading researchers in the empowerment area revealed that there was no research base in the specific area of developing a measurement for health professionals to assess their own use of empowering strategies. Due to a lack of research in this specific area, the literature on instrumentation was examined and the advice from experienced researchers in instrument development

was sought to determine the most appropriate and effective measurement tool for achieving the research intent.

The results of the literature review and researchers' advice regarding instrumentation indicated a summated rating scale, specifically a 5-point Likert scale, would provide the most accurate and practical form for fulfilling this study's research intent. With a summated rating scale, health professionals can determine their orientation to their use of empowering strategies by summing the point value for each item because each response is associated with a point value. The point values are reversed on negatively worded items (Gay, 1987).

The following presents the basis for the decision to use the 5-point Likert scale. Summated rating scales, equal-appearing interval scales, and cumulative scales are the three major types of scales used in behavioral research. Of these scales, "the summated rating scale seems to be the most useful in behavioral research" (Kerlinger, 1986, p. 455). Compared to other types of scales, a Likert scale, which is a type of summated rating scale, provides the same reliability and ability to discriminate among individuals' responses while being easier to develop. Another advantage of the Likert scale is that by providing 5 options along a continuum, it allows for intensity or a range of perceived frequency of use by the respondent. Additionally, Likert scales can be constructed to meet a wide range of needs in the area of behavioral research (Kerlinger, 1986). The Likert scale format also offers a quick and efficient form for assessing behaviors. Further, respondents can also independently complete these scales in a wide variety of settings. Because

of the advantages of the Likert scale, these scales are commonly used in behavioral research so health professionals' familiarity with Likert scales enhances their ability to efficiently complete the instrument (Gronlund, 1985).

The second step, generation of the items which are empowerment strategies, occurred in two ways. Strategies are specific examples of behaviors that operationalize a principle of empowering health education. Initially, it was thought that the model could serve as a basis to develop strategies; however, it was ineffective to comprehensively convert such a model into behavioral strategies. As a result, the principles which were included in the conceptual framework validated by the experts were used as a basis for developing an extensive list of strategies. In addition, the literature review and the author's professional experience and expertise in the health education field were used to ensure a comprehensive set of strategies. Guidelines for item generation established by Dillman (1978), Fowler (1988), and Sudman and Bradburn (1985) provided reference. This process generated 136 strategies or items and provided a sufficient starting point, considering the need to eliminate items based on item analysis procedures (Oddi, 1986). The items were twice critiqued, revised, and reduced in number. The criteria for revising and eliminating items were clarity of statements, redundancy of items, multiple concepts within an item, and adequate representation of all principles.

Next, these strategies or potential test items were reviewed for clarity and comprehension by a group of doctoral students in Adult Learning from Montana State University. This group examined the list for clarity of the individual items

and suggested editorial changes. A revised list of 101 strategies was sent to four of the six health education experts used in the initial process of establishing the validity of the theoretical framework (see Appendix D). The experts were sent a cover letter indicating the general instructions, a list of the eight principles, and a listing of the strategies that operationalized each principle (see Appendix E). Most importantly, the experts were requested to designate whether the items within the principle fully operationalized the content of the principle. In addition, they were asked to make suggestions regarding item's wording, usefulness, clarity, and relevancy and to designate the best and worst items within the principle.

As a result of these critiques, a pilot-test version of the self-assessment instrument was compiled containing a total of 79 items. To determine a form for field testing, the pilot test was given to 32 health educators in the Bozeman, Montana area. The pilot tests were mailed to the participants at their worksites with instructions for return via a self-addressed stamped envelope. The principles for human subject research were observed by maintaining anonymity for each respondent and using one standard instrument for each respondent. The purpose of the pilot test was two-fold: (1) to determine item discrimination and (2) to assess clarity of items and of instructions. The instructions accompanying the pilot test requested the participants not only to respond to the items, but also to comment on clarity of the wording of the items and instructions, on the format of the instrument, and to offer any other suggestions (see Appendix F). All the comments and critiques of the instrument were recorded either next to the item or in the

comment section on the instrument. Improvements in the instrument format, directions, and other variables were made based on this input.

The quantitative results of the pilot test were then assessed. Item discrimination refers to the degree to which items discriminate or differentiate among test takers. Frequencies and correlations were calculated to determine item discrimination. Frequencies of responses for each item were used to determine if the item elicited a variety of responses. Ideally, each item score should fall at opposite ends of the scale for health educators using empowering strategies compared to those infrequently using empowering strategies (Gay, 1980, p. 268). Each item score was correlated to the total score in order to determine if the item contributed positively to the total score. A high correlation between the item score and the total score indicated high item scores paired with high total scores and low item scores paired with low total scores. A low correlation between item score and total score indicates no relationship between the two scores (Gay, 1980). Non-discriminating items were revised or eliminated.

Based on the results of the pilot test, the next step in the development of the instrument was the generation of the 49-item field-test version (see Appendix G). The field-test version contained a cover page, cover letter, instructions, 49 items, and questions assessing the participant's background. An example of one item is the following: "I provide examples of how their health issues are influenced by social factors." The 5-point Likert scale includes the following choices: 0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Frequently, and 4 = Always.

The field-test instrument was administered to 64 health care professionals. As with the pilot test, the principles for human subject research were observed. The professionals completing HESS included registered nurses, dietitians, physical therapists, and occupational therapists in the state of Montana. Approximately half of these professionals volunteered to complete the instrument while attending professional workshops. The other half were requested to complete the instrument at their worksites by this researcher or by a professional co-worker who had been contacted by this researcher. Those professionals requested to complete the instrument in their professional setting represented a variety of practice settings and professional practices. Professionals practicing in hospitals, community health clinics, home health agencies, and schools were requested to complete the instrument.

The raw data collected using the instrument were then entered into a dBase program and the SPSS/PC Advanced Statistics V2.0 software package was used for data analysis. Statistical analysis of the data included frequency of responses, correlation of item score to total score, correlation of item score to total principle score, Cronbach alpha for reliability, and descriptive statistics of the demographic information. Based on the item analysis, the final version of HESS was determined by eliminating 6 items of the 49-item field test (see Appendix H). The basis for item deletion was an item's low correlation to total score and total principle score.

## Validity and Reliability

The field-test version was used to establish the reliability and the remaining phases of validity of the instrument. Generally, validity is defined as the degree to

which a test or instrument measures what it is intended to measure (Gay, 1987). The two standard types of validity that were established in this research project were construct and content validity (Kerlinger, 1986).

Content validity answers the question, "Is the substance or content of this measure representative of the content or the universe of content of the property being measured?" (Kerlinger, 1986, p. 417). The two major standards of ensuring content validity are the representative collection of items and appropriate methods of test construction (Nunnally, 1978). In order to determine the content validity, it is necessary to establish the full content domain and then determine whether the instrument represents the full domain. Content validation is determined by expert judgment when a group of experts carefully examines the content domain and how well the items represent the intended content area (Gay, 1980).

The initial phase of content validity for this research occurred when the national jury of experts established the principles as representing the full content domain of empowering health education. The jury of experts completed the next phase of content validity by determining the degree of correspondence between the representation of the items and the empowerment principles (Gronlund, 1985).

Construct validity is the most important type of validity. A construct is a psychological characteristic that explains some aspect of behavior and can account for certain differences among individuals. Construct validity determines the "degree to which a test measures an intended hypothetical construct" (Gay, 1987, p. 131). The process of establishing construct validity is a difficult task that involves testing

hypotheses deduced from a theory of the construct. There are three facets to the process of establishing construct validity: (1) specifying the domain of tasks or observable dimensions of behavior related to the construct, (2) deriving hypotheses regarding instrument performance from the theory underlying the construct, and (3) verifying the hypotheses with empirical research (Kerlinger, 1986, Nunnally, 1978). Two steps in the process were completed in this research. These initial steps included developing the principles as the framework or construct of empowering health education and then defining the domain of observable behaviors which serve as the items for the instrument (Gronlund, 1985). These steps were critiqued by the national jury of experts.

After the initial content and construct validity of the instrument were established, one type of reliability, determining the internal consistency of the instrument, was established. The internal consistency of the instrument determines the degree to which each item draws upon the same construct. The internal consistency of this instrument was established by calculating a Cronbach's alpha. Since the items are measuring the same construct, this method assumes that they are positively correlated with one another. The average correlation of an item with all other items within the instrument was calculated; high correlations indicate internal consistency (Norusis, 1986).

# CHAPTER 4

# RESULTS: THEORETICAL FRAMEWORK

## Principles of Empowering Health Education for Health Professionals

This section presents the findings of the first of two research intents for this study, developing a theoretical framework for empowering health education. The findings for the second research intent, developing an instrument for assessing health professionals' use of empowerment strategies will be presented in Chapter 5. As discussed in Chapter 3, a set of principles was the most appropriate format for accomplishing both research intents, that is delineating a theoretical framework and developing an assessment measurement for health professionals.

Since a theoretical framework specifically for empowering health education had never been developed, the content and scope of the initial set of principles were derived from a review of empowerment and health education literature. This initial set of principles, along with the other material already described, was sent to the jury of experts for their critique and determination of construct validity. The set of seven principles sent to the jury can be found in Appendix A. The jury was requested to comment on the clarity and accuracy of each principle and then determine if the principles adequately and accurately represented the empowering

approach to health education. Since the jury pool reflected both health educators and adult educators and empowerment does not have a unified theoretical basis, the jury's critique reflected a wide variety of experiential backgrounds and interpretations of empowerment. The diversity resulted in a wealth of viewpoints and considerations.

Overall, the jury supported the principles as an adequate and accurate representation of empowering health education. The jury indicated two major criticisms. The first area of concern was the apparent emphasis on the dyadic nature of the relationship between health professionals and clients without appropriate emphasis on communities or groups. The second was an inadequate emphasis on the social, political, and structural barriers that impact health status which consequentially led to an overemphasis on the individualistic nature of health education. These criticisms were addressed during the revision of the principles by rewording to allow for both individual and group interpretation, adding a principle to reflect the appropriate emphasis on the social, political, and economic nature of empowering health education, and further clarifying the intent of the principles, so that these principles reflect empowering health education within the context of health professionals.

The principles were also reordered to reflect a movement from a more traditional understanding of health education to encompassing a broader social, economic, and political role for health professionals utilizing empowering health education. This order better reflects the initial steps of the empowerment process

(i.e., beginning where people are) and was supported by several jurist's comments about the difficulty in introducing, operationalizing, and encouraging utilization of empowerment theory to health professionals. For example, "How what you do could help the ordinary health educator who is struggling to apply theory to the practical everyday business of attempting to help individuals and groups of people make changes in their lives," and "I've found traditionally trained folks find it hard to read 'philosophy.' In other words, they need whatever help they can get."

A major change in emphasis from the original set involved deleting the developmental description of the empowering learning process. One jury member commented, "I like this definition as developmental;" however, others were critical of the concept because it lacked clarity ("What constitutes developmental learning?"). Moreover, it seemed to imply a linear progression of development and learning. The criticisms were especially prominent as they commented on the model. For example, one jury member commented, "Because you describe this as a developmental model, it sounds as though empowerment is linear in nature with a beginning and an ending. This suggests that it is a process that one goes through one time and then the person is empowered in all health areas. I am not at all sure that is true." Another observed that even "though clients move through these phases, it isn't always straight ahead, there can be curves and setbacks and hard times and easier times and plateaus and skids." Still another jurist emphasized the iterative nature of the process and pointed out the need for "loops to fall back on or returns seem needed, the model is fine for one person who is linear as can be.

In health care, little things may dash your confidence, back to the drawing board is a reality."

This set of principles was then revised based upon the testimony of the experts and a continual review and assessment of the literature to assure that the principles comprehensively and accurately represented empowering health education. The following principles represent the theoretical framework of empowering health education based on the jury's determination of construct validity and the literature review. The remainder of this section presents each of the eight principles with a synopsis of the supporting comments of the jury and the literature review.

Principle 1. Establishing the Framework for Interaction

Health care professionals will acknowledge their personal working philosophy, promote dialogue and critical thinking, and create a caring, respectful environment for interaction.

Testimony of Jury. This principle, a combination of two principles found in the original set, basically established the important components for a framework of interaction. The first aspect of this principle, health professionals acknowledging their personal working philosophy, was well supported by the jury with comments such as "good" and "very important." Since this aspect was included in the first principle of the original set, several jury members stated their concerns about the dyadic nature of this and other principles and the implication that all empowering health education is initiated by professionals.

The second aspect of this principle, health professionals promoting dialogue and critical thinking, was well supported as components of other principles in the original set. Promoting dialogue was endorsed by jury members with comments such as, "good emphasis on joint dialogue," but it was critiqued with questions such as "mutually beneficial interaction?" and "Does this reflect mutuality and merging of professional knowledge with individual?" These questions provide an example of the divergent backgrounds and understanding of empowerment terminology. The process of dialogue, as found in the literature reviewed and as defined by Paulo Freire, creates mutual exchange and benefits for participants and professionals.

Critical thinking was not specifically mentioned in the original set of principles, but was suggested by a jury member to be included with dialogue. Components of critical thinking were contained in several principles, such as examining perception of reality and critical analysis; however, the wording "perception of reality" was troublesome to some jury members, as represented by the comment, "I think health care professionals might misinterpret this as advocating for acceptance of 'abnormal thinking.'"

The last segment of this principle, creating a caring, respectful environment for interaction, was added after a comment from a jury member describing her recent experiences with health professionals; "Others (health professionals) made us feel like children, that we had been bad because we failed to understand something, asked too many questions, presumed that we had a right to an opinion." In addition, several reviews of the literature indicated this point's importance in

empowering education. This aspect of the principle was indirectly supported by jury members in relation to the use of the word "client" in the original set of principles: "I'd avoid the objectification of people as clients." "Individuals seeking assistance or persons" were suggested as alternatives by the jurist.

Support of Literature. Creating a positive, respectful learning environment is critical if the interaction between health care consumers and health care practitioners is to lead to meeting the needs of consumers (Hiemstra & Sisco, 1990; Joos & Hickam, 1990). "A learning environment is all of the physical surroundings, psychological or emotional conditions, and social or cultural influences affecting the growth and development of an adult engaged in an educational enterprise" (Hiemstra, 1991, p. 9).

What constitutes a positive learning environment for empowering health education? Several areas of the learning environment, such as the psychological, emotional, social, and cultural spheres, are becoming increasingly recognized as critical influences on health education (Clement, 1987; Dunst, Trivette, & Deal, 1988; Fried, 1980; Marsick & Smedley, 1989). Creating an environment for empowering health education requires considering the psychological, emotional, social, and cultural influences on education, which, in turn, mandates several roles for health professionals. These roles for the health professional include awareness and articulation of their philosophical orientation, awareness and portrayal of specific attitudes and perceptions that enhance empowerment and learning,

attention to language, and use of dialogue and critical thinking. A discussion of these roles follows.

Professionals' awareness regarding their personal philosophy of working with people or their helping styles is extremely important, yet it is not well examined in health education theory and practice (Achterberg & Trenkner, 1990; Timmreck et al., 1987). Contemplating and articulating a personal working philosophy is important for many reasons; Hiemstra (1990) discussed four important considerations. Awareness of a personal philosophy can help educators promote an understanding of human relationships, can help sensitize them to the needs required for positive human relationships, can help them recognize their personal values, and can allow for greater consistency and flexibility while working. Working from a philosophy allows educators to "know not only what they are to do, but also are aware of the principles and the reasons for so acting" (Elias & Merriam, 1982, p. 9).

Research findings have shown that certain helping styles employed by professionals may foster dependence and create ineffective learning environments, even if the professional intent is to promote positive results in clients. Certain health care and educational practices induce dependence in consumers, which leads to helplessness and the inability to develop the skills and confidence necessary to solve or cope with health problems (Dunst, Trivette, Davis, & Cornwell, 1988). In part, this can occur when professionals do not examine their helping style (Dunst & Trivette, 1987). When professionals articulate their philosophical framework to

consumers, it provides clarity for both professionals and consumers regarding defining roles, voicing of expectations, assessing consumer needs, and discussing personal learning and teaching styles (Hiemstra & Sisco, 1990).

Health professionals' attitudes and perspectives are another important component in creating a positive learning environment (Dunst, Trivette, Davis, & Cornwell, 1988; Rogers, 1957). This has been well researched beginning in the 1950's with Carl Rogers identifying empathy, genuineness, and acceptance of clients as key attributes of professionals in client-centered care. Qualitative work in empowering health education has confirmed the importance of these attributes of health professionals as well as identified the need for health professionals to be respectful, supportive, and nonjudgmental. Research findings have indicated that empowerment is more likely when health professionals are nonjudgmental, are truly interested in and listening to consumers' concerns, and indicate that they perceive consumers as capable and competent (Dunst & Trivette, 1987; Shelton et al., 1989).

Communication styles and patterns are another important factor in creating an empowering environment for health education. Health professionals' realization that language is a powerful tool that can either facilitate or inhibit the learning process is critical for promoting empowerment with consumers (Roberts & Krouse, 1988; Rosser, 1986; Waitzkin, 1989). In health education, language is important in two ways. First, the language used in health education can be highly technical and complex and can be used by health professionals to reinforce the paternalistic or

authoritarian approach by creating confusion, intimidation, and dependency in consumers (Roberts & Krouse, 1988). Health professionals need to be aware of the potential for creating this situation.

Secondly, language is critical for consumers communicating about their life experiences. While employing an empowering approach to health education, health professional's communication style should not be one of "allowing" consumers to talk, but rather health professionals must realize that the consumers' language communicates feelings, thoughts, and power. Consumers' language also create their reality by connecting their inner world to the outer world, which in health education situations, is the health professional. Enhancing the consumers' voice through using their language will increase the consumers' power and assist professionals in understanding consumers' reality (Joos & Hickam, 1990; McGuire, 1983; Rosser, 1986).

When using an empowering approach, health professionals can best communicate through the use of dialogue where both professionals and consumers actively discuss the problem through sharing knowledge and recreating reality. Dialogue is key in developing consumers' critical thought abilities. Critical thought is a valuable learning tool leading to a more realistic view of health problems and thereby leading to a more effective approach to resolving problems (Minkler & Cox, 1980; Shor & Freire, 1987; Wallerstein & Bernstein, 1988).

In addition to the psychological, social, and cultural aspects of learning, physical features of the learning environment play an important role of the learning

in promoting optimal learning. The physical environment needs to be comfortable and appropriate with attention paid to temperature, noise, lighting, furnishings. A positive physical environment will limit distraction during the learning process and connote respect for the learners (Fulton, 1991; Hiemstra & Sisco, 1990).

Principle 2. Consumer as Primary Decision-Maker

Health care consumers are primary managers and decision-makers of their health care as they define their problems, set goals, and generate solutions with health professionals serving as facilitators/consultants/collaborators.

Testimony of Jury. Overall, the jury of experts felt that the principle of consumer as decision maker was key in empowering health education. One jury member said clients should "make decisions regarding their own health care and treatment" and another expert commented "participating in the process to help make the agenda -- decide on the education process as well as receiving it . . . the educator must involve the client in the planning process." Another supportive comment by a jury member was that "I define empowerment as the client defining, analyzing, and finding ways to alleviate their own problems to their own satisfaction."

Several experts also felt a realistic view of consumers' goals is needed. One expert explained, "A person without money, who is alone in the world, not used to having personal and collective power, without education--those things certainly have

an impact on the situation you are concerned with. We shouldn't pretend that in a capitalistic system, a poor person will have the same potential to develop . . . as a person with money." Also, one expert believed that "we have to learn how to adapt to some things, compensate as best we can, and accept certain elements that we can't change."

Support of Literature. The primary tenet of empowering health education is a consumer-oriented approach to learning and problem-solving in which consumers sense they are in control of their health care (Anderson et al., 1991; Dunst, Trivette, & Deal, 1988; Fahlberg et al., 1991; Wallerstein & Bernstein, 1988). Consumers can direct their health care to include growth and development that can impact them only on a personal level or can also impact their social environment (Fahlberg et al., 1991). In order for consumers' growth and development to occur, it is essential that consumers actively experience their role as competent managers of their health care. The most important strategy for promoting this sense of control is placing the role of decision-maker with consumers. This requires that health professionals assume a collaborative, facilitative, and supportive role assisting consumers in realistically defining and resolving health problems (Dunst, Trivette, Davis, & Cornwell, 1988; Shelton et al., 1989).

Unfortunately, the norm in health education for the past several decades can be described as a paternalistic model, which dictated that expert professionals assume responsibility for consumers' care and decisions by, in part, defining

consumer problems and prescribing solutions to consumers' health care problems (Fahlberg et al., 1991; Parham, 1990). The paternalistic mode can be problematic in many ways. It is unlikely that professionals will realistically define problems as multifactorial in nature; they are more likely to define them according to the parameters of the traditional, individualistic, medical model. Following this, the consumers' treatment or solution of their health problems, generated by the health professionals with little consumer input as narrowly defined problems, will most likely be ineffective. Oftentimes, these prescriptive therapeutic plans have been presented as the only viable, effective option to solving the health problem (Parham, 1990).

Besides presenting a treatment plan having limited scope and effectiveness, a paternalistic approach robs consumers in other ways. As Dunst, Trivette, Davis, and Cornwell (1988) describe: "Taking control and filling in missing resources may seem expedient in terms of meeting the needs of children with health impairments and their families, but in the long run it deprives them of enabling experiences that will make them more competent and better able to understand and manage their children's special health needs" (p. 79). Traditional paternalistic health education does not allow consumers to experience themselves as managers of their health care. Unfortunately, this approach has negative short-term and long-term implications for consumers. In the short term it is ineffective in solving their health problem, and, in the long-term, they do not gain the competencies and perspectives

to become more capable of reaching their goals (Dunst, Trivette, & Deal, 1988; Shelton et al., 1989).

Principle 3. Personalized, Contextually-Based, Experiential Learning

Participants engage in a process of learning either individually or collectively whereby they enhance their ability to generate knowledge through reflection upon their experiences and to personalize health-related information based on the context of their lives.

Testimony of Jury. Overall, the jury supported the content of this principle with comments such as "Well said," "This is OK as is," and "Good." Also, one expert "would like to see 'context' added, i.e., clients recognize characteristics in their environment or context that can enhance or impede development learn to work constructively within and beyond it." Adding the term context was also supported with the comments, "I think you may need more emphasis on the social/economic/political context for empowerment as the basic foundation" and "empowerment education is highly contextually related."

Learning by generating knowledge through reflection on experiences was supported by several jury members as they commented "people learn from . . . reflect(ion) on their experiences (which are also social)," and "empowerment . . . enables individuals to engage in dialogue with each other about their own perceptions of reality, life experiences, then through dialogue based on

knowledge/experiential learning, people adopt actions and then develop ongoing praxis as they continue to reflect."

Some jurists commented that empowering, experientially-based learning within groups, rather than individually, was the valid representation of empowerment. As stated earlier in the literature review, this researcher feels that empowerment can begin at any level and so included both the individual and collective learning environments (Rappaport, 1989).

Support of Literature. An important tenet of the empowerment approach to health education is contextually-based, experiential learning (Dunst, Trivette, & Deal, 1988; Rappaport, 1981). If new competencies and perceptions are critical for consumers achieving personal growth and social transformation, the focus of learning needs to be experientially-based within their life experiences and context. Rappaport states, "Where new competencies need to be learned, they are best learned in a context of living rather than in artificial programs where everyone knows that it is really the expert who is in charge" (Rappaport, 1981, p. 16).

Experientially-based learning has received little or no attention in the health field because the predominant paternalistic model frames health-related learning experiences within the interaction between health-care providers and consumers with little discussion, respect, or attention given to the potential learning experiences of the consumers within their life contexts. The period between the formal professional-consumer sessions are viewed as times usually spent attempting

to comply and adhere to professionally-generated treatment plans instead of creating and reflecting upon learning experiences in their everyday experiences (Rappaport, 1981).

The paternalistic model also views professional experts as possessing the totality of information and knowledge necessary for understanding and treating health problems (Parham, 1990). In empowering health education, professional knowledge is considered important. However, it is not representative of the totality of knowledge nor is it the only source of knowledge. Empowering health education is contextually-based learning; both professionals and consumers share the perception that consumers are capable of generating knowledge, and both professionals and consumers possess the skills necessary for generating knowledge. Reflecting upon experiences, or praxis, is the primary means by which consumers can generate the critical knowledge in meeting their health-care goals (Kopp, 1989; Reisch et al., 1981; Wallerstein & Bernstein, 1988). Overall, an empowering approach should focus on combining and balancing health professionals' and consumers' knowledge and information.

Principle 4. Building upon Skills and Strengths

Health professionals will assist the consumer in building upon their existing skills and abilities in order to better manage their health and achieve their health-related goals.

Testimony of Jury. This principle was added to the original set after two jury members specifically recommended including this aspect of empowering health education. One member commented that the principles adequately represented empowering health education with the one exception that "I believe the issue of promoting competence is missing here." Another expert commented, "Also support and recognition of existing competencies," and in another section, this same jurist said, "Get support for knowledge and experiences and competencies." Also one expert defined empowerment as "the enhancement of capacities of people to control their own lives."

The experts indirectly supported this concept of empowering education as they positively commented on the second assumption which stated that people have or can develop the power and capabilities creating health lives. One expert, referring to this assumption, commented, "Should be a principle?" and another said, "I like the way you acknowledge that developing the power and capabilities is not an isolated process, and that everything you have done in your life, the skills, confidence you've gotten, are important here as well."

Support of Literature. Acknowledging and enhancing existing consumer skills and abilities as well as promoting the acquisition of new skills and competencies are important aspects of empowering health education (Anderson et al., 1986; Dunst, Trivette, & Deal, 1988; Rappaport, 1987). Recognition of the multifactorial nature of health problems calls for acceptance of the fact that the

skills, strengths, and competencies needed to solve problems range broadly from personal behavior change skills to social action for health (Anderson et al., 1986). For example, financial management, stress management, assertiveness training, and political organization may all be skills needed to adequately address health problems.

Once the importance of developing skills and competencies has been acknowledged, the health care interaction can focus on respecting and enhancing pre-existing skills and then identifying and developing those skills necessary for either solving or coping with the health problem. Acknowledging the existence and development of consumer skills has not been highlighted in the traditional, paternalistic, information-giving approach. Skills were discussed as means to comply and adhere to the narrowly focused health-care plan devised for consumers by professionals (Parsons et al., 1988).

Principle 5. Consumers' Development of Confidence and Empowering Perspective

The health professional's role is to foster consumers' belief that they are capable of taking greater control of the health-related factors influencing their lives and that progress in achieving goals is the result of the participants' actions and not solely that of the health professional or health program.

Testimony of Jury. Overall, the jury was supportive of this principle as evidenced by comments such as "The ultimate aim of empowerment!!" and "Good."

Other experts suggested minor wording changes for clarification, indicating overall general support for the principle.

Support of Literature. The development of a sense of efficacy in the consumers' abilities is essential to the on-going process of personal and social change. This sense of confidence in their ability to make changes at a personal and social level develops by active engagement in the change process together with acknowledgment of the part they played in that process. Health professionals fulfill their role in promoting efficacy by providing and identifying experiences for consumers to manage their health care and then directing acknowledgement of consumers' accomplishments to the consumers. Professionals should use caution in appropriating credit for consumers' accomplishments to either themselves or health agencies (Dunst, Trivette, & Deal, 1988; Roberts & Thorsheim, 1986).

Gaining a sense of efficacy through involvement with empowering experiences at one level of analysis has been shown to create a greater chance that consumers will be willing to address problems at other levels (Counter, Paul, Conti, 1990; Fahlberg et al., 1991; Rappaport, 1988). Because health education usually occurs on a personal level, an empowering health education experience will initially occur on a personal level and then lead to a greater understanding and involvement in changing the social environment (Minkler, 1989).

Principle 6. Professionals Facilitate Linkage with Resources

Health professionals facilitate consumers' linkages with a comprehensive and relevant array of resources, such as technical information, support groups, and structural and system information.

Testimony of Jury. Overall, the expert jury supported this principle with some commenting "Good" or "OK," but many commented on the unclarity of two phrases used in the original principle. These unclear phrases were replaced with more direct and clear terminology. As a result of the substitutions, the principle's content was supported by the jury.

Support of Literature. The process of referring consumers to other health-care professionals and services is a common-place and expected professional responsibility in the traditional model of health care. However, an empowerment approach to health education greatly expands the professionals' role in resource-referral. For example, professionals could promote the consumers' confidence and ability in obtaining technical information typically the property of professionals (Horton, 1990). Keeping technical information only within a professional sphere may perpetuate the mystique of the paternalistic approach to health education and inhibit consumers' involvement in understanding and resolving health problems (Clement, 1987).

The responsibility of health professionals goes beyond realizing and acknowledging systemic and structural barriers that prevent or inhibit consumers from achieving their health goals to promoting acquisition of the skills, information, and confidence that can impact or change such structural barriers (Fahlberg et al., 1991, Parsons et al., 1988). Finally, health professionals need to encourage consumers to create the important needed resources that are currently unavailable. Considering the many influences on health, these resources can address a wide range of the social, economic, and political, and personal factors impacting health status (Wallerstein & Bernstein, 1988). For example, consumers can promote the creation of a clearinghouse listing the current community, state, national, and international legislative issues impacting health and then consumers can organize in order to address these issues.

Principle 7. Influences of Social, Political, Economic Environments

Health professionals will assist consumers in assessing the social, political, and economic factors affecting their health status and discuss ways in which to influence and/or gain control of those factors.

Testimony of Jury. The jury of experts were highly supportive of this principle and emphasized that an empowering approach implied addressing cultural and social context, as well as organizational structures influencing health. As previously mentioned, the major criticism of the original set of principles was the

lack of emphasis on the social, political, structural, and economic factors influencing health and ways in which to impact those factors. The influence of society on health was a part of one principle, but according to the jury, it was not adequately addressed in the principles in terms of importance and of the variety in types of influences. As a result, this principle was added to provide the appropriate emphasis on the broader influences of health and the broader roles assumed by consumers in order to influence these factors.

Examples of comments from the jury reflecting this included "An empowering process demands analysis of social conditions," "influence of other social systems not just a large societal influence," and "impact on culture on individuals and institutions." Others commented "How about structures-organizations-seems they must be impacted and changed to cooperate," "don't forget dominating structures and hierarchical relationships," and "Proactive stance for individual suggests activism in a much broader (i.e., social and political) context." Finally, a jurist wrote, "I also hope you will be able to contrast the concept of empowerment to the all too common practice of 'blaming the victim'; focusing health education almost exclusively on trying to change individual behavior, when so much poor health is strongly related to social, cultural, and environmental factors which are not readily changed by individual life-style modification."

Support of Literature. The pervasive paternalistic, individualistic approach to health education that has existed for several decades has focused on the

individual in isolation with little regard for the social, political, cultural, economic, spiritual, and historical environment. The underlying assumption of this approach is that individuals can profoundly influence their health status through lifestyle and behavior change. This assumption places the majority of blame and responsibility for the individual's health on the individual without acknowledging the influence of the many factors listed above (Fahlberg et al., 1991; Fried, 1980).

The empowerment model suggests a more realistic distribution of cause or blame by recognizing the multitude of causal factors shaping the health problem. An empowering approach will more realistically address the role of individual behavior change and also help link the everyday experiences of the consumer to the larger social context. Such an approach will greatly expand the range of solutions for health problems. The solutions will not only encompass individual behavior change, but also discuss how the individual can personally and collectively address social, political, and economic factors affecting personal health and the health of their communities (Fahlberg et al., 1991; Minkler, 1989).

Principle 8. Professional's Involvement with Empowering Health Care

Health professionals will strive to empower themselves and work in partnership with consumers and lay communities on health-related issues.

Testimony of Jury. Overall, the experts strongly felt as one wrote that, "Often to achieve success for the client's health related goals the physician also

needs to be empowered. Freire would look at education for social change which includes the system and the physician. Could they not empower each other? Where is the reciprocity that is usually thought of in a facilitative relationship?" Also, this principle was supported with comments like, "Implication of this broader perspective (i.e., social and political) for providers needs to be developed," "Don't forget the roles of structures, organizations, institutions and how they are organized to control, patronize, organize both the providers and the clients- Can't this also be included in your instrument for assessment?" and "Can you have an educator practicing an 'empowerment' model without dealing with the structures in which they work? At least some awareness of this if you don't deal with it."

Although the experts were supportive, some were concerned with the original principle eliciting comments such as "professional must be careful not to become controlling in another way within this process" and "Also, . . . you may have placed a bit too much emphasis on the role of the health professional in the empowerment process (thereby creating yet another area of professional control)."

The concept of joint participation was supported: "Again participation seems to be an essential term so people can enter into the process, thus developing the power, etc. It is a joint endeavor-partnership," "Can you also suggest ways participation could change the structures as well as the process of education. What does the client-patient-partner in the process bring to the relationship?"

In order for health professionals to promote an empowering approach to health education, professionals need to empower themselves personally,

professionally, and in the organizational structures in which they work. A critical analysis of their personal and professional environment is important if they are to fully understand the concept of empowerment and be able to serve as role models for consumers and other professionals (Hegar, 1988; Furlong, 1987).

Support of Literature. In addition to personal and professional empowerment, health professionals need to enhance their skills in working collaboratively with individuals, groups, and communities. For most professionals, this will require additional training to develop the attitudes and skills necessary to optimize the learning experiences for consumers and themselves. A collaborative approach implies that health professionals understand that positive change will result when both professionals and consumers realize the extent and limits of both parties' knowledge and abilities. Working collectively and cooperatively will produce the changes necessary for a healthier existence (Fahlberg et al., 1991; Shelton et al., 1989).

Additionally the role of health professionals will broaden significantly as they themselves begin to realize the multitude of other factors impacting health. Health professionals can go beyond disseminating technical information and promoting individual behavior change within consumers to reducing barriers within the health care system and within political, economic, cultural, and social structures that contribute to health status (Swift & Levin, 1987).

# CHAPTER 5

## RESULTS: DEVELOPMENT OF INSTRUMENT

This section presents the findings of the second of two research intents for this study, developing an instrument for assessing health professionals' use of empowering strategies. The findings for the first research intent, developing a theoretical framework for empowering health education is presented in Chapter 4. The theoretical framework used for developing the instrument was a set of eight principles, which a jury of 13 experts determined to have content validity and the initial establishment of construct validity.

A list of behavioral strategies operationalizing each principle was developed and sent to four expert jury members to establish content validity of the items for each principle. A Likert scale instrument, Health Education Strategies Scale (HESS), was then generated and pilot tested with health professionals in the Bozeman, Montana area. Based on the qualitative and quantitative results of the pilot test, a field-test version of HESS was produced and tested with health professionals within Montana.

This chapter will describe the outcome of the statistical analysis for the field-test version of HESS. The first section will outline the demographics data of

the participants, the second section will describe the item analysis of HESS, the third will evaluate the reliability of HESS.

## Demographics

The demographic information which was gathered in the "Individual Background" section of HESS included age, gender, profession, level of education, practice setting, length of professional practice. Table 1 displays frequencies and percentages of these demographic characteristics.

Respondents included 97% women (N=62) and 3% men (N=2); 95% Caucasian, 3% Native Americans; with a mean age of 38. The major professions participating were dietitians (39%) and nurses (31%). The level of education for the majority of the participants was a bachelor degree (64%) or masters degree (20%). Many of the participants practiced either at a hospital (21%) or a health department (25%). The number of years of professional experience ranged from 1 to 32 years with a mean of 11 years.

## Item Analysis

Item analysis for the field-test version of HESS included determination of the mean item score, the standard deviation of the scores, the lowest and highest score totals for the field test, the frequency distribution of responses, the item score to total score Pearson correlations, the item score to total principle score Pearson

Table 1. Demographics of Respondents, Field-Test Version of HESS.

| | Frequency | Percent | Cumulative |
|---|---|---|---|
| Gender | | | |
| Women | 62 | 96.9 | 96.6 |
| Men | 2 | 3.1 | 100.0 |
| Race/Ethnic Identification | | | |
| Caucasian/White | 61 | 95.3 | 95.3 |
| Native American | 3 | 4.7 | 100.0 |
| Profession | | | |
| Nursing | 20 | 31.3 | 31.3 |
| Dietetics | 25 | 39.1 | 70.3 |
| Physical Therapy | 2 | 3.1 | 73.4 |
| Occupational Therapy | 1 | 1.6 | 75.0 |
| Health Education | 3 | 4.7 | 79.7 |
| Pharmacy | 2 | 3.1 | 82.8 |
| Other | 11 | 17.2 | 100.0 |
| Level of Education | | | |
| High School Diploma | 1 | 1.6 | 1.6 |
| Associate Arts | 4 | 6.3 | 7.8 |
| Bachelor | 41 | 64.1 | 71.9 |
| Masters | 13 | 20.3 | 92.2 |
| Doctoral | 1 | 1.6 | 93.8 |
| Vocational Certification | 2 | 3.1 | 96.9 |
| No Degree | 2 | 3.1 | 100.0 |

Table 1. Continued.

| | Frequency | Percent | Cumulative |
|---|---|---|---|
| Practice Setting | | | |
| Hospital | 21 | 33.9 | 33.9 |
| Hospital-Based Clinic | 3 | 4.8 | 38.7 |
| Private Business | 3 | 4.8 | 43.5 |
| Health Department | 16 | 25.0 | 69.4 |
| Non-Profit Clinic | 1 | 1.6 | 71.0 |
| For-Profit Clinic | 2 | 3.1 | 74.2 |
| Nursing Home | 3 | 4.7 | 79.0 |
| Other | 13 | 21.0 | 100.0 |
| Years of Professional Practice | | | |
| 0-5 | 24 | 38.7 | 38.8 |
| 6-10 | 10 | 16.1 | 54.8 |
| 11-15 | 10 | 16.1 | 70.9 |
| 16-20 | 9 | 14.5 | 85.4 |
| 21-25 | 5 | 8.1 | 93.5 |
| 26-30 | 3 | 4.8 | 98.3 |
| 31-35 | 1 | 1.6 | 100.0 |
| Age | | | |
| 21-25 | 4 | 6.0 | 6.0 |
| 26-30 | 10 | 15.5 | 21.5 |
| 31-35 | 10 | 15.5 | 37.0 |
| 36-40 | 11 | 17.0 | 54.0 |
| 41-45 | 17 | 27.0 | 81.0 |
| 46-50 | 7 | 11.0 | 92.0 |
| 51-55 | 3 | 5.0 | 97.0 |
| 56-60 | 1 | 1.5 | 98.5 |
| 61-65 | 1 | 1.5 | 100.0 |

correlations, item to item correlation matrix, and principle to principle correlation matrix.

Negatively worded items were included to discourage any tendency to answer in a socially desirable manner or patterned response. Thirty-seven items were positively worded, and 12 items were negatively worded. A score of 2.0 was given to items with no response. These results also reflect that the responses of the negatively worded items were recorded with a 4=0, 3=1, 1=3, and 0=4.

The mean score for the 49-item HESS scale was 123.8 with a standard deviation of 17.9. The mean response choice was 2.53. The lowest score in the 49-item field test was 88 and the highest score was 157, with the highest possible score of 196.

A valid instrument must be able to differentiate among respondents. The extent to which HESS differentiated among respondents was assessed by calculating frequency distributions for each item (see Table 2.) The frequency distributions showed 24 of the 49 items had respondents choosing the entire range of values, 23 items had respondents choosing a range of 4 possible values, and only 2 items had respondents choosing 3 of the 5 possible values. The standard deviation of items ranged from .63 to 1.2, which indicates diversity on a 5-point Likert scale. The frequency distribution of responses indicated a reasonable spread of scores; that is, the empowerment instrument appears to differentiate among respondents.

Table 2. Frequency of Responses, Field-Test Version of HESS.

| Question | Response Choice Frequency (%) | | | | |
|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 |
| 1 | 3 (5) | 7 (11) | 25 (39) | 25 (39) | 4 (6) |
| 2 | | 4 (6) | 15 (23) | 30 (47) | 15 (23) |
| 3 | | 7 (11) | 22 (34) | 27 (42) | 8 (13) |
| 4 | 2 (3) | 6 (9) | 21 (33) | 32 (50) | 3 (5) |
| 5 | | 6 (9) | 13 (20) | 29 (45) | 16 (25) |
| 6 | | 3 (5) | 12 (19) | 26 (41) | 23 (36) |
| 7 | | 1 (2) | 21 (33) | 19 (30) | 23 (36) |
| 8 | | | 6 (9) | 23 (36) | 35 (55) |
| 9 | 1 (2) | 2 (3) | 4 (6) | 33 (52) | 24 (38) |
| 10 | 1 (2) | 9 (14) | 15 (23) | 26 (41) | 13 (20) |
| 11 | | 2 (3) | 33 (52) | 25 (39) | 4 (6) |
| 12 | 15 (23) | 32 (50) | 13 (20) | 4 (6) | |
| 13 | 1 (2) | 1 (2) | 9 (14) | 28 (44) | 25 (39) |
| 14 | 4 (6) | 7 (11) | 27 (42) | 16 (25) | 10 (16) |
| 15 | 4 (6) | 11 (17) | 15 (23) | 25 (39) | 9 (14) |
| 16 | | 6 (9) | 20 (31) | 14 (22) | 24 (38) |
| 17 | 2 (3) | 3 (5) | 16 (25) | 22 (34) | 21 (33) |
| 18 | 4 (6) | 4 (6) | 31 (48) | 21 (33) | 4 (6) |
| 19 | 3 (5) | 2 (3) | 19 (30) | 28 (44) | 12 (19) |
| 20 | 1 (2) | 2 (3) | 18 (28) | 25 (39) | 18 (28) |
| 21 | 3 (5) | 16 (25) | 23 (36) | 16 (25) | 6 (9) |
| 22 | 2 (3) | 13 (20) | 34 (53) | 13 (20) | 2 (3) |
| 23 | | 2 (3) | 19 (30) | 29 (45) | 14 (22) |
| 24 | 4 (6) | 8 (13) | 19 (30) | 28 (44) | 5 (8) |
| 25 | | 4 (6) | 5 (8) | 23 (36) | 32 (50) |
| 26 | 4 (6) | 12 (19) | 21 (33) | 24 (38) | 3 (5) |
| 27 | | | 12 (19) | 38 (59) | 14 (22) |
| 28 | 1 (2) | 3 (5) | 10 (16) | 36 (56) | 14 (22) |
| 29 | | 2 (3) | 7 (11) | 32 (50) | 23 (36) |
| 30 | | 2 (3) | 5 (8) | 38 (59) | 19 (30) |
| 31 | 3 (5) | 19 (30) | 27 (42) | 14 (22) | 1 (2) |
| 32 | | 7 (11) | 16 (25) | 21 (33) | 20 (31) |
| 33 | 8 (13) | 31 (48) | 22 (34) | 3 (5) | |
| 34 | 6 (9) | 9 (14) | 21 (33) | 25 (39) | 3 (5) |

Table 2. Continued.

| Question | Value (Frequency/%) | | | | |
|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 |
| 35 | | 1 (2) | 15 (23) | 33 (52) | 15 (23) |
| 36 | 4 (6) | 22 (34) | 29 (45) | 9 (14) | |
| 37 | 18 (28) | 20 (31) | 19 (30) | 6 (9) | 1 (2) |
| 38 | 12 (19) | 19 (30) | 13 (20) | 17 (27) | 3 (5) |
| 39 | 1 (2) | 7 (11) | 13 (20) | 23 (36) | 20 (31) |
| 40 | 1 (2) | 18 (28) | 39 (61) | 6 (9) | |
| 41 | | 2 (3) | 14 (22) | 34 (53) | 14 (22) |
| 42 | | 3 (5) | 24 (38) | 25 (19) | 12 (19) |
| 43 | | 3 (5) | 17 (27) | 26 (41) | 18 (28) |
| 44 | | 1 (2) | 11 (17) | 28 (44) | 24 (38) |
| 45 | 1 (2) | 2 (3) | 23 (36) | 31 (48) | 7 (11) |
| 46 | 2 (3) | 7 (11) | 19 (30) | 21 (33) | 15 (23) |
| 47 | 7 (11) | 9 (14) | 12 (19) | 26 (41) | 10 (16) |
| 48 | 12 (19) | 27 (42) | 14 (22) | 8 (13) | 3 (5) |
| 49 | 3 (5) | 19 (30) | 17 (27) | 17 (27) | 8 (13) |

The Pearson correlations for each of item score to the total group score are listed in Table 3. Also indicated in Table 3 is whether the item was positively or negatively worded. The correlation coefficients ranged from -.44 to .75. Many of the lowest coefficients were negatively worded. In fact, the items with the six lowest correlation coefficients ranging from -.44 to .20 were all negatively worded items. The Pearson correlations for the item to total group principle score are found in Table 4. The correlations ranged from -.32 to .75.

Table 3. Pearson Correlations for Item Score to Total Instrument Score for 49-Item HESS.

| Item | Correlation | | Item | Correlation | |
|---|---|---|---|---|---|
| 1. | .58 | | 26. | .57 | |
| 2. | .32 | | 27. | .65 | |
| 3. | .50 | | 28. | .55 | |
| 4. | .02 | Negatively Worded | 29. | .75 | |
| 5. | .53 | | 30. | .54 | |
| 6. | .29 | | 31. | .31 | Negatively Worded |
| 7. | .23 | Negatively Worded | 32. | .03 | Negatively Worded |
| 8. | .45 | | 33. | .02 | Negatively Worded |
| 9. | .61 | | 34. | .43 | |
| 10. | .45 | | 35. | .67 | |
| 11. | .29 | | 36. | .28 | Negatively Worded |
| 12. | -.44 | Negatively Worded | 37. | .66 | |
| 13. | .54 | | 38. | .75 | |
| 14. | .26 | | 39. | .49 | |
| 15. | .55 | | 40. | .33 | Negatively Worded |
| 16. | -.08 | Negatively Worded | 41. | .63 | |
| 17. | .32 | | 42. | .57 | |
| 18. | .67 | | 43. | .32 | |
| 19. | .59 | | 44. | .47 | |
| 20. | .63 | | 45. | .41 | |
| 21. | .25 | | 46. | .48 | |
| 22. | .38 | Negatively Worded | 47. | .60 | |
| 23. | .42 | | 48. | -.10 | Negatively Worded |
| 24. | .35 | | 49. | .46 | |
| 25. | .32 | Negatively Worded | | | |

Table 4. Pearson Correlations for Item Score to Total Principle Score for 49-Item HESS.

| Principle 1 | | Principle 4 | | Principle 7 | |
|---|---|---|---|---|---|
| 7. | .51 | 9. | .70 | 3. | .67 |
| 14. | .37 | 12. | -.31 | 5. | .70 |
| 22. | .50 | 19. | .69 | 15. | .75 |
| 38. | .71 | 30. | .65 | 24. | .55 |
| 39. | .70 | 36. | .40 | 33. | .39 |
| | | 41. | .66 | 34. | .63 |
| **Principle 2** | | **Principle 5** | | **Principle 8** | |
| 10. | .69 | 8. | .60 | 21. | .53 |
| 11. | .52 | 13. | .61 | 23. | .50 |
| 16. | .13 | 27. | .69 | 45. | .48 |
| 17. | .44 | 31. | .55 | 46. | .68 |
| 29. | .59 | 35. | .66 | 47. | .67 |
| 37. | .67 | 43. | .42 | 48. | .04 |
| | | | | 49. | .65 |
| **Principle 3** | | **Principle 6** | | | |
| 1. | .61 | 2. | .50 | | |
| 4. | .35 | 6. | .40 | | |
| 18. | .59 | 20. | .74 | | |
| 25. | .56 | 26. | .67 | | |
| 28. | .61 | 32. | .24 | | |
| 40. | .39 | 42. | .71 | | |
| 44. | .59 | | | | |

## Reliability

The reliability of the 49-item HESS scale, using Cronbach's alpha coefficient, was .89. Gay (1980) indicates acceptable correlations at .7 and above. To assess whether the higher Cronbach alpha coefficient indicated redundancy of items, an item to item correlation matrix and principle to principle matrix were examined. Results of the item to item correlation matrix did not indicate redundancy. The highest correlation was .67, with only 6 of the correlations above .6. Results of the principle to principle correlation matrix indicated a slight degree of redundancy in Principles 2, 3, and 4. These principles contained some correlations between .6 and .7, which indicates approximately one-half of the variance accounted for by the same factor. The majority of the correlations did not indicate redundancy.

## Deletion of Items

A goal in the development of HESS was to create an instrument that would allow a respondent to complete it within a reasonably short period of time such as 10 to 15 minutes. This could be accomplished with an instrument with approximately 40 items. Therefore, the 49-item field-test version of the HESS instrument allowed for deletion of items if the item analysis and reliability results indicated certain items did not positively contribute to the instrument. Even though the reliability of the 49-item HESS instrument was quite acceptable, certain item to

total score correlations were quite low. As a result, it was necessary to assess the effect of deleting a total of six items with the lowest item to total score and total principle score correlation coefficients was assessed to determine the change in correlations and reliability. First the three items (items 12,16,48) with the lowest to total score were deleted. Then items 4, 32, and 33 which had the next three lowest correlations were deleted. These six items represented six different principles, resulting in all principles represented by at least five items. The next section will review the results of the two phases of item deletion.

Deletion of Items 12, 16, 48

After deleting items 12, 16, and 48 from the instrument, the Pearson correlations for the item to total score ranged from -.01 to .76. The Pearson correlations for the item to total principle score ranged from -.24 to .78. The reliability of the 46-item HESS scale, using Cronbach's coefficient alpha, was .91.

Deletion of Additional Items 4, 32, 33

Because of these low correlations, three additional items (4, 32, 33) were deleted from the instrument. The Pearson correlations for the item score to total score were as listed in Table 5. The correlation coefficients ranged from .17 to .77. All items, excluding items 7 and 36, were significant at the .05 level. The Pearson correlations for the item to total principle score is found in Table 6. The correlations ranged from .37 to .79. The reliability of the 43-item HESS scale, using Cronbach's coefficient alpha, was .91.

Table 5. Pearson Correlations for Item Score to Total Instrument Score for 43-Item HESS.

| Item | Correlation | | Item | Correlation | |
|---|---|---|---|---|---|
| 1. | .57 | | 26. | .61 | |
| 2. | .31 | | 27. | .66 | |
| 3. | .48 | | 28. | .58 | |
| 5. | .54 | | 29. | .75 | |
| 7. | .17 | Negatively Worded | 30. | .56 | |
| 8. | .45 | | 31. | .25 | Negatively Worded |
| 9. | .64 | | 34. | .45 | |
| 10. | .44 | | 35. | .69 | |
| 11. | .30 | | 36. | .21 | Negatively Worded |
| 13. | .52 | | 37. | .68 | |
| 14. | .28 | | 38. | .77 | |
| 15. | .56 | | 39. | .49 | |
| 17. | .37 | | 40. | .30 | Negatively Worded |
| 18. | .68 | | 41. | .65 | |
| 19. | .63 | | 42. | .58 | |
| 20. | .66 | | 43. | .30 | |
| 21. | .25 | | 44. | .49 | |
| 22. | .32 | Negatively Worded | 45. | .45 | |
| 23. | .45 | | 46. | .50 | |
| 24. | .39 | | 47. | .62 | |
| 25. | .30 | Negatively Worded | 49. | .46 | |

Table 6. Pearson Correlations for Item Score to Total Principle Score for 43-Item HESS.

| Principle 1 | | Principle 4 | | Principle 7 | |
|---|---|---|---|---|---|
| 7. | .51 | 9. | .77 | 3. | .64 |
| 14. | .37 | 19. | .77 | 5. | .73 |
| 22. | .50 | 30. | .68 | 15. | .77 |
| 38. | .71 | 36. | .34 | 24. | .59 |
| 39. | .70 | 41. | .68 | 34. | .63 |
| **Principle 2** | | **Principle 5** | | **Principle 8** | |
| 10. | .63 | 8. | .60 | 21. | .55 |
| 11. | .50 | 13. | .61 | 23. | .56 |
| 17. | .57 | 27. | .69 | 45. | .54 |
| 29. | .67 | 31. | .55 | 46. | .72 |
| 37. | .75 | 35. | .66 | 47. | .65 |
| | | 43. | .42 | 49. | .68 |
| **Principle 3** | | | | | |
| | | **Principle 6** | | | |
| 1. | .60 | | | | |
| 18. | .65 | 2. | .46 | | |
| 25. | .55 | 6. | .45 | | |
| 28. | .66 | 20. | .79 | | |
| 40. | .41 | 26. | .74 | | |
| 44. | .62 | 42. | .76 | | |

The results of the deletions indicate that an instrument can be obtained that is more reliable, as established by Cronbach alpha, and useful, as determined by a shorter response time. However, it is important to discuss whether reducing the items at this point in the instrument development might threaten the content validity of the instrument. Options include obtaining a larger sample size for the 49-item HESS, revising the six items and then obtaining a larger sample size for the 49-items HESS, deleting 3 items, or deleting 6 items. The option to delete 6 items was chosen because each principle is well represented and the instrument can be completed in a acceptably short period of time. Overall, the results indicate the beginning of a reliable and valid instrument.

# CHAPTER 6

## FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

This chapter presents the findings and conclusions associated with this study's research on empowering health education and suggests recommendations for future practice and for research. The content of this chapter is divided into three components; namely, (a) summary of the findings of the study, (b) presentation of the study's conclusions, and (c) list of recommendations for research and for practice.

### Summary of Research Findings

The purpose of this research was to construct a theoretical basis for empowering health education and to develop a tool for health professionals to use to assess their use of empowering health education strategies. A set of principles guiding the practice of empowering health education was sent to a 13-member jury of adult education and health education experts. A definition of empowering health education, a goal for empowering health education, four assumptions, and a model depicting empowering health education were also included with the set of principles. The testimony of these experts resulted in a series of eight principles

which validly identified empowerment as practiced by health educators. The literature also provided specific support for these eight principles.

An instrument was then developed operationalizing these eight principles. After a pilot study was conducted to produce discriminating items and clear items and instructions, a field test was conducted with 64 Montana health care professionals. This process produced a finalized 43-item form of the HESS instrument. The instrument's reliability, determined by a Cronbach alpha, was .91.

The utility of the instrument was confirmed by several points. The final version took respondents approximately 10 minutes to complete. Written and verbal comments provided by the respondents indicated that the format aided their ability to respond, rather than creating barriers to response.

Several unexpected benefits occurred during the development of HESS. Several respondents indicated they became interested in the topic of empowerment upon completion of the HESS and requested additional information and opportunities for dialogue. Additionally, many of the jury members on the expert panel positively commented on the study. For example, "I am very impressed with the work you have sent me for review. It is obvious that you have given this topic careful thought," "Neat project; I like it very much," "I am excited about it and think it can be good," "I think that this work is generally very good . . . you are to be congratulated on doing an excellent job," and "This is really good stuff, Lynn, and an important dissertation is likely to result" were examples of general comments provided by the jury members.

## Presentation of Conclusions

Four research questions were addressed as a means to achieve the research intent. In addition to providing a tool for accomplishing the research, these research questions also serve as an organizing structure for presenting the research conclusions.

1. What theoretical construct can both delineate empowering health education and serve as a basis for developing behavioral strategies operationalizing empowering health education?

The theoretical construct of empowering health education developed for this study served two important functions. The construct's first function was to accurately and comprehensively delineate empowering health education. The second function was to provide a form, such as a model or set of principles, capable of precisely and completely operationalizing the construct of empowering health education into behavioral strategies.

According to a jury of experts, the eight principles of empowering health education developed in this study adequately define empowering health education and serve as a valid basis for identifying strategies representing empowering health education. The following eight principles are the final set for the theoretical framework:

Principles of Empowering Health Education for Health Professionals

1. Establishing the Framework for Interaction

   Health care professionals will acknowledge their personal working philosophy, promote dialogue and critical thinking, and create a caring, respectful environment for interaction.

2. Consumer as Primary Decision-Maker

   Health care consumers are the primary managers and decision-makers of their health care as they define their problems, set goals, and generate solutions with the health professional serving as facilitator/consultant.

3. Personalized, Contextually-Based, Experiential Learning

   Participants engage in a process of learning whereby they enhance their ability to generate knowledge through reflection upon their experiences, and personalize health-related information based on the context of their lives.

4. Building upon Skills and Strengths

   Health professionals will assist the consumer in building upon their existing skills and abilities in order to better manage their health and achieve their health-related goals.

5. Consumers' Development of Confidence and Empowering Perspective

   The health professional's role is to foster consumers' belief that they are capable of taking greater control of the health-related factors influencing their lives and that progress in achieving goals is the result of the

participants' actions and not only those of the health professionals or health program.

6. Professionals Facilitate Linkage with Resources

   Health professionals facilitate consumers' linking with a comprehensive and relevant array of resources, such as technical information, support groups, structural and system information.

7. Influences of Social, Political, Economic Environments

   The health professional will assist the consumer in assessing the social, political, and economic factors affecting their health status and discuss ways in which to impact and/or gain control of those factors.

8. Professional's Involvement with Empowering Health Care

   The health professional will strive to empower themselves and work in partnership with consumers and lay communities on health -related issues.

The theoretical construct of empowering health education that best met the two requirements for this study was this set of eight principles. The eight principles allowed for the conceptualization of the complex, multi-factorial nature of empowering health education, initiation of the process of construct validation, and development of an accurate and representative list of behavioral strategies that operationalize the construct.

Developing principles not only served to meet the needs of this research study, but also provided a perspective revealing continuity within the literature on

empowerment theory. Similar sets of principles defining the empowerment concept were the method of choice for leading theoreticians and researchers examining empowerment in their respective fields. Other forms, such as models, have also been used to define the construct of empowering health education, but these forms are difficult to operationalized comprehensively and accurately into behavioral strategies.

Overall, the set of eight principles provided an accurate and comprehensive framework of empowering health education as validated by the jury of experts. The principles also served as a manageable framework for developing behavioral strategies representing the empowering health education construct.

2. What are the strategies or behaviors used by health professionals that exhibit the theoretical construct of empowering health education, and of these strategies which represent the construct?

The strategies embedded in the 43 strategies of the final version of HESS most accurately and comprehensively represented the principles of empowering health education in practice. A critical step in developing an instrument for health professionals to assess their use of empowering strategies was operationalizing the theoretical construct of empowering health education. This was accomplished by generating behavioral strategies from each of the eight principles that collectively served as the theoretical construct of empowering health education. Several

sources were used to determine the content of the behavioral strategies. These sources include the literature on empowerment, experiences of professionals, and suggestions from this study's jury of experts. The jury of experts also determined content validity of the behavioral strategies. Each behavioral strategy was assigned to only one principle. The behavioral strategies used for this study were representative of the numerous possibilities exemplifying the principle. The representative set of behavioral strategies proved to be the most critical and descriptive indicators of each principle as determined by this researcher and the jury of experts. The final version contained 43 behavioral strategies, with each principle represented by at least 5 strategies.

3. What type of instrument would best assist health professionals' appraisal of their own use of empowering health education strategies?

The findings indicated a summated rating scale, specifically a 5-point Likert scale, provided an accurate and practical form for fulfilling this study's research intent. Results from the field-test version indicated that the Likert scale produced the beginnings of a valid and reliable instrument. The Likert scale format offered a quick and efficient form for assessing behaviors. Additionally, health professionals said they became aware of new health education strategies that would enhance their practice. The Likert instrument evidently conveyed information

about empowering health education while the data was collected. This was an unexpected benefit. Overall, a Likert format best accomplished the research intent.

4. Can a reliable and valid instrument be developed for health professionals' to evaluate their use of empowering health education strategies?

Results of HESS's pilot and field tests indicated the beginning of a reliable and valid instrument. Reliability, using Cronbach alpha, was .91 for the 43-item HESS test, which is well above the standard acceptable level of .7. Item analysis for HESS included determination of the mean item score, the standard deviation of the scores, the frequency distribution of responses, the item score to total score Pearson correlations, the item score to total principle score Pearson correlations, and item to item and principle to principle correlation matrices. The mean score for the 43-item field-test version of HESS was 97 with a standard deviation of 17.4. The Pearson correlations for the final 43-item HESS scale for the item to total score ranged from .17 to .77. The Pearson correlations for the item to total principle score ranged from .34 to .79.

The jury of experts used for this research study determined HESS to have content validity and the initial establishment of construct validity. The initial results indicate that the HESS will be a useful and practical approach for assessing health professionals' use of empowering strategies.

## Recommendations

The following recommendations are made based on the study's findings and conclusions. Three categories of recommendations are discussed: (a) recommendations for enhancing health professionals' practice, (b) research recommendations for improving the usefulness of the HESS, and (c) research recommendations for developing the empowering health education construct.

### Recommendations for Enhancing Health Professionals' Practice

1. HESS should be nationally distributed to health professionals interested in assessing their use of empowering health education strategies. HESS can be promoted and distributed through the many professional groups and health care organizations. HESS could be used in conjunction with professional and organizational training for improving the environment for empowering health education.

2. Dialogue about the HESS scale should initiate critical discussions about the current status of the philosophical basis of health education and the need for its advancement. Professionals should thoughtfully examine their personal orientation toward empowerment and discuss how to improve their ability to create empowering environments. Also professionals should discuss the need for awareness of their current personal philosophy of health education and the impact

of that philosophy on their practice. As the literature review indicated, the philosophy of health education is inadequately developed (Timmreck et al., 1987).

3. Health professionals using the empowerment approach need to assess their professional environment to determine if the environment allows them to effectively model an empowering approach and provide an empowering environment for consumers. Creating partnerships among professionals and consumers to improve health status through empowering health education requires an examination of all factors impacting health, including the immediate organizational environment of professionals.

4. Health professionals need to develop a wide range of additional knowledge and skills when adopting an empowering approach to health education in order to address the multi-factorial, complex nature of empowering health education. For example, learning how to work more collaboratively with consumers will be critical for health professionals. Also health professionals will need to enhance their understanding and utilization of critical thinking, experiential learning, consumer advocacy, and social reform as these represent a small sampling of the many necessary and diverse skills required for empowering health education.

5. A joint partnership of health care practitioners, researchers, administrators, and consumers needs to complete three steps in order to adopt successfully an empowering approach to health education. The first step is to identify the many components of society that impact health in general or influence specific health problems. The second step requires educating those involved

regarding their role in contributing to and resolving health problems. The third step involves identifying and promoting the skills and knowledge needed by those adopting and maintaining an empowering approach. For example, consumers need to be educated about their roles in working collaboratively with health professionals. Within their communities, consumers need to learn how to identify and resolve community issues affecting health. Consumers will also need to assess to what extent existing community, state, and federal health programs create empowering environments. One of the many contributions provided by health professionals will be evaluating state and federal health-related policies regarding effectiveness in enhancing empowering health education.

6. Research is needed to determine the consumer's perception of the degree of the health professional's use of empowering strategies. For example, if a health professional's HESS score is high, indicating frequent use of empowering strategies, does the health care consumer perceive that the professional frequently employs empowering strategies?

Research Recommendations for Improving the Usefulness of the HESS Scale

1. The following research studies would enhance the reliability, validity, and usefulness of the HESS scale.

a. The construct validity of the HESS should be confirmed by deriving hypotheses from the construct and then verifying the hypotheses by empirical studies and other research methods. Future research findings should assist in

determining construct discriminability, or how the construct is similar and dissimilar to other constructs (Kerlinger, 1986). The HESS's construct validity should also be confirmed by using the statistical method of factor analysis of variance. This method will require at least 500 participants from a homogeneous sample to determine the factors or categories within the large number of variables composing the concept of empowering health education. A factor analysis would analyze the independent and interactive effects of the independent variables on the total score of the HESS, the dependent variable. The results of the analysis will yield categories that either confirm or suggest revision of the eight principles.

b. Replicate the study among health professionals from various geographical and professional populations to determine if location or professional affiliation suggest a unique pattern of utilizing empowering strategies.

c. Develop a profession-specific HESS to enhance the effectiveness of health professionals within their unique practice group in assessing their use of empowering strategies. For example, a HESS scale specifically for dietitians may be more effective than the general HESS scale.

d. An additional reliability test, a test-retest, should be conducted to determine the stability of the HESS, or the degree to which scores are consistent over time.

e. Establish criterion-related validity of HESS to determine how well the HESS scores could estimate current performance of health professionals. Criterion-related validity will address whether health professionals employing

empowering health education strategies create more empowering opportunities for consumers and whether those health professionals scoring high on the HESS scale actually practice the empowerment approach.

2. An interpretation of the continuum of possible HESS scores needs to be developed when health professionals calculate their total scores and scores within each principle. Suggestions and guidance for enhancing health professionals' empowering approach to health education also needs to be developed and made available to interested health professionals.

3. Research needs to be conducted on how to best utilize the HESS scale in promoting the concept of empowering health education. How can the HESS be used to stimulate interest in developing empowering health education? Also, how can the HESS best enhance staff training, development, and continuing education?

4. Norms for total score and standard deviation need to be developed for respondents within the general health professional population, specific groups of professionals, specific practice settings, and various lengths of practice.

5. Further research is needed from consumers' viewpoints to determine what empowering strategies employed by health professionals are important and effective. For example, a HESS-type instrument based on the perceptions and experiences of consumers could further direct professionals' effective use of empowering strategies.

Research Recommendations for Future Research in the Theoretical and Applied Basis of Empowering Health Education

1. Once empowering health education is in place, there is a need to conduct longitudinal studies to understand the developmental and process-oriented nature of empowering health education. Longitudinal studies can also determine the long-term effects of the empowering health education approach on all levels and factors involved in health. This research may best be completed using qualitative research methods, such as case studies and participatory research.

2. Research is needed to study the most effective situations in which to initiate the empowerment process. Is the empowerment approach most effectively initiated at the individual level where the individual then influences the community? Or is the empowerment approach most effectively initiated at the community level where the community process also positively effects the individual? Results of this research would improve the effectiveness of an empowering approach and generate greater understanding of the empowerment process.

3. Research is needed to identify the wide range of skills and knowledge useful to those involved at all levels of the empowerment approach and then to determine how best to educate the participants. For example, what skills do health professionals need in order to re-orient consumers from a paternalistic, individualistic model of health education to an empowering approach to health education? What skills do consumers need to generate resources, such as self-help groups?

4. There is a need to identify and study the dynamic interdependence of the many factors of empowering health education, such the political, social, economic, cultural, spiritual, and organizational factors. Additionally, research is needed to determine how, and to what extent, these facets either promote or obstruct empowering health education. How do program policies influence the one-to-one interaction of health professionals and consumers? What aspects of the health professionals' work-related organizational structure promote or impede creating empowering environments for consumers?

5. There is a need to determine the content and form of assessment tools that can identify and evaluate the factors (political, economic, social, cultural, spiritual, organizational) contributing to health problems within a specific context. For example, what tool would allow a community to assess the alcohol education factors needed to either prevent or decrease teenage drinking?

## Summary

The research intent to develop a theoretical basis for empowering health education for professionals and an instrument for assessing individual health professional's use of empowering strategies was successfully completed. A set of eight principles served as the theoretical framework and the HESS instrument proved to possess the initial qualifications of a reliable and valid instrument.

# REFERENCES

Achterberg, C., & Trenkner, L.L. (1990). Developing a working philosophy of nutrition education. Journal of Nutrition Education, 22(4), 189-193.

Adams, F. (1975). Unearthing seeds of fire: The idea of Highlander. Winston-Salem, NC: John Blair.

Anderson, R.M., Funnell, M.M., Barr, P.A., Dedrick, R.F., & Davis, W.K. (1991). Learning to empower patients: Results of professional education for diabetes educators.Diabetes Care, 14(7), 584-590.

Arntson, P., & Droge, D. (1988). Addressing the value dimension of health communication: A social science perspective. Journal of Applied Communication Research, 16(1), 1-15.

Ashcroft, L. (1987). Defusing "empowering": The what and the why. Language Arts, 64(2), 142-156.

Bernard, M. (1988). Taking charge: Strategies for self-empowered health behaviour among older people. Health Education Journal, 47(2/3), 87-90.

Clark, P. (1989). The philosophical foundation of empowerment. Journal of Aging and Health, 1(3), 267-285.

Clement, C. (1987). Women and health: From passive to active. Health Promotion, 25,(4), 5-8.

Cohen, A.C. (1981). Human service. In A.W. Chickering (Ed.), The Modern American College (pp. 512-528). San Francisco, CA: Jossey-Bass.

Counter, J.E., Paul, L.C., & Conti, G.J. (1990). Conrad, Montana: A community of memories. In G.J. Conti & R.A. Fellenz (Eds.), Cultural Influences on Adult Learning, (pp. 1-8). Bozeman, MT: Center for Adult Learning Research.

Dillman, D. (1978). Mail and telephone surveys: The total design method. New York: Wiley.

Dunst, C.J., & Trivette, C.M. (1987). Enabling and empowering families: Conceptual and intervention issues. School Psychology Review, 16(4), 443-456.

Dunst, C.J., Trivette, C.M., Davis, M., & Cornwell, J. (1988). Enabling and empowering families of children with health impairments. Children's Health Care, 17(2), 71-81.

Dunst, C.J., Trivette, C.M., & Deal, A.G. (1988) Enabling and empowering families: Principles and guidelines for practice. Cambridge, MA: Brookline Books.

Dunst, C.J., Trivette, C.M., & LaPointe, N. (in press). Toward clarification of the meaning and key elements of empowerment.

Elias, J.L., & Merriam, S. (1982). Philosophical foundations of adult education. Malabar, FL: Krieger.

Fahlberg, L.L., Poulin, A.L., Girdano, D.A., & Dusek, D.E. (1991). Empowerment as an emerging approach in health education. Journal of Health Education, 22(3), 185-193.

Fowler, F. (1988). Survey research methods. Beverly Hills: Sage.

Freire, P. (1970a). The adult literacy process as cultural action for freedom. Harvard Educational Review, 40(2), 205-225.

Freire, P. (1970b). Cultural action and conscientization. Harvard Educational Review, 40(3), 452-477.

Freire, P. (1970c). Pedagogy of the oppressed. New York, NY: Continuum.

Fried, R. (1980). Empowerment vs. delivery of services. Concord, NH: New Hampshire State Department of Education.

Fulton, R.D. (1991). A conceptual model for understanding the physical attributes of learning environments. In R. Hiemstra (Ed.) Creating Environments for Effective Adult Learning. San Francisco: Jossey-Bass.

Furlong, M. (1987). A rationale for the use of empowerment as a goal in casework. Australian Social Work, 40(3), 25-30.

Gaventa, J. (1988). Participatory research in North America. Convergence, 21(2/3), 19-27.

Gaventa, J., & Horton, B. (1981). A citizen's research project in Appalachia, USA. Convergence, 14(3), 30-41.

Gay, L.R. (1980). Educational evaluation and measurement. Columbus, OH: Bell & Howell.

Gay, L.R. (1987). Educational research. Columbus, OH: Bell & Howell.

Glanz, K. (1979). Strategies for nutritional counseling. Journal of the American Dietetic Association, 74, 431-437.

Gochman, D.S. (1982). Labels, systems, and motives: Some perspectives for future research. Health Education Quarterly, 9, 167-174.

Goodwin-Johansson, C. (1988). Educating the adult patient. Lifelong Learning, 11(7), 10-13.

Gorbach, S.W., Morrill-LaBrode, A., Woods, M.M., Dwyer, J.T., Selles, W.D., Henderson, M., Insull, W., Goldman, S.,Thompson, D., Clifford, C., & Sheppard, L. (1990). Changes in food patterns during a low-fat dietary intervention in women. Journal of the American Dietetic Association, 90(6), 802-809.

Gronlund, N.E. (1985). Measurement and evaluation in teaching. New York, NY: Macmillan Publishing.

Gruber, J., & Trickett, E. (1987). Can we empower others? The paradox of empowerment in the governing of an alternative public school. American Journal of Community Psychology, 15(3), 353-371.

Gutterman, L. (1990). A day treatment program for persons with AIDS. American Journal of Occupational Therapy, 44(3), 234-237.

Haney, P. (1988). Providing empowerment to the person with AIDS. Social Work, 33(3), 251-253.

Hegar, R. (1989). Empowerment-based practice with children. Social Science Review 63(3), 372-383.

Hiemstra, R. (1991). Aspects of effective learning environments. In R. Hiemstra (Ed.) Creating Environments for Effective Adult Learning. San Francisco: Jossey-Bass.

Hiemstra, R., & Sisco, B. (1990). Individualizing instruction: Making learning personal, empowering, and successful. San Francisco: Jossey-Bass.

Hibbard, M. (1984). Empowerment through the needs assessment process. Journal of Sociology and Social Welfare, 11(1), 112-133.

Horton, M. (1990). Myles Horton's views on learning in the social environment. In R.A. Fellenz & G.J. Conti Social Environment and Adult Learning (pp. 9-18). Bozeman, MT: Center for Adult Learning Research.

Joos, S.K., & Hickam, D.H. (1990). How health professionals influence health behavior: Patient-provider interaction and health care outcomes. In K. Glanz, F.M. Lewis, & B.K. Rimer (Eds.), Health Behavior and Health Education. San Francisco: Jossey-Bass.

Kayman, S. (1989). Applying theory from social psychology and cognitive behavioral psychology to dietary behavior change and assessment. Journal of the American Dietetic Association, 89(2), 191-193.

Kent, G. (1988). Nutrition education as an instrument of empowerment. Journal of Nutrition Education, 20(4), 193-195.

Kerlinger, F.N. (1986). Foundation of behavioral research. Orlando, FL: Holt, Rinehart, and Winston.

Kilian, A. (1988). Conscientisation: An empowering, nonformal education approach for community health workers. Community Development Journal, 23(2), 117-123.

Kopp, J. (1989). Self-observation: An empowerment strategy in assessment. Social Casework, 70(5), 276-284.

Marsick, V.J. (1988). Learning in the workplace: The case for reflectivity and critical reflectivity. Adult Education Quarterly, 38(4), 187-198.

Marsick, V.J., & Smedley, R.R. (1989). Health education. In S. Merriam & P. Cunningham (Eds.), Handbook of Adult and Continuing Education (pp. 502-512). San Francisco: Jossey 'Bass.

McGuire, M.B. (1983). Words of power: Personal empowerment and healing. Culture, Medicine, and Psychiatry, 7(3), 221-240.

Miller, R., & Wolff, C. (1981). The helping professions. In A.W. Chickering (Ed.), The Modern American College (pp. 529-537). San Francisco, CA: Jossey Bass.

Minkler, M. (1987). Health education, health promotion and the open society: An historical perspective. Health Education Quarterly, 16(1), 17-30.

Minkler, M., & Cox, K. (1980). Creating critical consciousness in health: Applications of Freire's philosophy and methods to the health care setting. International Journal of Health Services, 10(2), 311-322.

Norusis, M. (1988). SPSS/PC+ advanced statistics V2.0. Chicago: SPSS.

Nunnally, J.C. (1978). Psychometric theory. New York: McGraw Hill.

Oddi, L.F. (1986). Development and validation of an instrument to identify self-directed continuing learners. Adult Education Quarterly, 36(2), 97-107.

Ozer, E.M., & Bandura, A. (1990). Mechanisms governing empowerment effects: A self-efficacy analysis. Journal of Personality and Social Psychology, 58(3), 472-486.

Parham, E.S. (1990). Applying a philosophy of nutrition education to weight control. Journal of Nutrition Education. 22(4), 194-197.

Parsons, R.J., Hernandez, S.H., & Jorgensen, J.D. (1988). Integrated practice: A framework for problem solving. Social Work, 33(5), 417-421.

Pinderhughes, E.B. (1983). Empowerment for our clients and for ourselves. Social Casework, 64(6), 331-338.

Rappaport, J. (1981). In praise of paradox: A social policy of empowerment over prevention. American Journal of Community Psychology, 9(1), 1-25.

Rappaport, J. (1987). Terms of empowerment/exemplars of prevention: Toward a theory for community psychology. American Journal of Community Psychology, 15(2), 121-148.

Reisch, M., Wenocur, S., & Sherman, W. (1981). Empowerment, conscientization, and animation as core social work skills. Social Development Issues, 5(2-3), 108-120.

Rinke, W.J. (1986). Holistic education: A new paradigm for nutrition education. Journal of Nutrition Education, 18(4), 151-155.

Roberts, B., & Thorsheim, H.I. (1986). A partnership approach to consultation: The process and results of a primary prevention field experiment. Prevention in Human Services, 4, 151-186.

Roberts, S.J., & Krouse, H.J. (1988). Enhancing self care through active negotiation. Nurse Practitioner, 13(8), 133-141.

Rody, N. (1988). Empowerment as organizational policy innutrition intervention programs: A case study from the Pacific Islands. Journal of Nutrition Education, 20(3), 133-141.

Rogers, C.R. (1957). The necessary and sufficient conditions for therapeutic personality change. Journal of Consulting Psychology, 21, 95-101.

Rosser, S.V. (1986). Teaching science and health from a feminist perspective. Elmsford, NY: Pergamon.

Sanson-Fisher, R.W., Campbell, E.M., Redman, S., & Hennrikus, D.J. (1989). Patient-provider interactions and patient outcomes. The Diabetes Educator, 15(2)., 134-138.

Shelton, T.L., Jeppson, E.S., & Johnson, B.H. (1987). Family-centered care for children with special health care needs. Washington, DC: Association for the Care of Children's Health.

Shor, I., & Freire, P. (1987). A pedagogy for liberation. South Hadley, MA: Bergin & Garvey.

Shor, I., & Freire, P. (1987). What is the "dialogical method" of teaching? Journal of Education, 169(3), 11-31.

Smith, J.A. (1981). The idea of health: A philosophical inquiry. ANS/Nursing Education, 3(3), 43-50.

Spence, D. (1988). Empowering the geriatric client. Educational Gerontology, 14(6), 557-566.

Steinbaum, E. (1990). Security and empowerment: The financial advocacy program. Social Policy, 20(3), 62.

Stromquist, N.P. (1988). Women's education in development: From welfare to empowerment. Convergence, 21(4), 5-17.

Sudman, S., & Bradburn, N.M. (1985). Asking questions. San Francisco: Jossey-Bass.

Swift, C., & Levin G. (1987). Empowerment: An emerging mental health technology. Journal of Primary Prevention, 8(1-2), 71-94.

Tandon, R. (1981). Participatory research in the empowerment of people. Convergence, 14(3), 20-27.

Timmreck, T.C., Cole, G.E., James, G., & Butterworth, D.D. (1987). The health education and health promotion movement: A theoretical jungle. Health Education, 18(5), 24-28.

Tones, B.K. (1986). Health education and the ideology of health promotion: A review of alternative approaches. Health Education Research, 1(1), 3-12.

Waitzkin, H. (1989). A critical theory of medical discourse: Ideology, social control, and the processing of social context in medical encounters. Journal of Health and Social Behavior, 30, 220-239.

Wallerstein, N., & Bernstein, E. (1988). Empowerment education: Freire's ideas adapted to health education. Health Education Quarterly, 15(4), 379-394.

Weaver, D.R. (1982). Empowering treatment skills for helping black families. Social Casework, 63(2), 100-105.

Yonemura, M. (1986). Reflections on teacher empowerment and teacher education. Harvard Educational Review, 56(4), 473-480.

Zacharakis-Jutz, J. (1988). Post-Freirean adult education: A question of empowerment and power. Adult Education Quarterly, 39(1), 41-47.

Zimmerman, M. A. (1990). Toward a theory of learned hopefulness: A structural model analysis of participation and empowerment. Journal of Research in Personality, 24, 71-86.

# APPENDICES

# APPENDIX A

# INITIAL THEORETICAL FRAMEWORK FOR EMPOWERING HEALTH EDUCATION

# I. EMPOWERING HEALTH EDUCATION

Within the past two decades, social and political forces have changed the concept of health from "an absence of disease" to "general well being and self-realization." Health educators need to respond to the changing nature of health by redefining the philosophy and principles of health education. The traditional, paternalistic model of health education, which developed with the "absence of disease" concept of health, prescribes that health care professionals assume power in the helping relationship and the patient remains passive. Research has shown that these types of relationships can create dependency on health professionals leading to client's sense of helplessness and hopelessness. This model of health education has proven relatively ineffective in preventing and treating today's health problems that are the result of an array of complex individual, social, spiritual, and political influences.

The concept of empowerment has been suggested as a philosophical base for a broad range of human services particularly in areas where the traditional, paternalistic model has been most ineffective. For example, select programs dealing with women's health and the AIDS epidemic have successfully adopted the empowerment philosophy. People with AIDS acknowledged the empowerment approach as the process that enabled them to develop the power and control over their lives necessary for hope and direction. Hope and direction were essential in adopting the attitude of LIVING with AIDS rather than developing a fatalistic outlook. Women who experienced empowerment through health education realized that impacting the system was necessary to solve problems, being well-informed consumers was not enough. These reflections portray precisely the goal of empowerment, to make ordinary people able to manage their health problems without constant recourse to health professionals.

The empowering health education approach may be best understood by contrasting it to the traditional medical model. Understandably, this looks at extremes in behavior, but is useful in discovering the differences between the two approaches. The traditional model focuses on the health professionals' ability to define and present solutions to the clients' health problems primarily through the didactic approach. In the empowering approach, clients share the power role with the health professionals. The professionals convey to the clients that they have the capability of understanding and learning how to manage their health problems. This is primarily accomplished by using strategies that require decisions to be made by clients. The empowering interaction is highly dynamic, where through dialogue, both individuals share and create knowledge and reflect on perspectives and experiences.

In the traditional approach, the time following the initial interaction with the health professional is characterized by the client's attempts to comply and adhere to the dictated prescription. In the empowerment process, this time is seen as an opportunity for client's discovery, connections, growth, and action. When new competencies necessary for coping with health problems must be learned, they are best learned in a context of life rather than solely within the health care environment.

The focus of the individual experiencing empowering health education changes from well-informed, compliant behavior in the traditional model to a proactive stance of creating healthy environments for self and others. In the empowerment approach, health professionals have the opportunity to add to their rich and complex experiences and skills. The overall experience is enlarging for everyone, especially as health professionals and clients, individually and collectively effect society's systems.

## II. DEFINITION

Empowering health education is a developmental learning process facilitated by health professionals whereby people can experience the potential to develop the power, capabilities, and resources to create healthy lives for themselves and others.

## III. GOAL

People will develop their abilities to act effectively on their environment creating healthy lives for themselves and others by connecting with internal and external sources of power, knowledge and skills to competently define, solve and evaluate their health problems.

## IV. ASSUMPTIONS

1. People seek to control and direct their lives and ultimately develop this potential to the fullest when they do for themselves rather than having others do for them. In responding to this desire, various types of power are needed to effect change on the individual and societal level.

2. People have or can develop the power and capabilities necessary for creating healthy lives. This development is an individualistic process based on past experiences, needs, learning styles, and social context.

3. Health problems are the result of individual and societal conditions, especially the lack of opportunities for people to develop the necessary power, skills, and knowledge to create healthy lives.

4. The relationship between health care providers and clients is important in achieving success for the clients' health-related goals. Health care practices and strategies utilized by professionals have the potential to facilitate the empowerment process or develop dependency on health professionals.

Comments:

## V. PRINCIPLES

1. Health care professionals will acknowledge the empowerment philosophy as a personal working philosophy of health education and discuss the assumptions and implications with the client.

Comments regarding clarity and accuracy:

2. The professionals view empowering health education as a developmental learning process whereby the clients experience greater control and direction over the factors affecting their health status.

Comments regarding clarity and accuracy:

3. The learning and teaching process emphasizes experiential learning where the clients learn to draw upon the richness of their life experiences, recognize and develop their learning styles, enhance their ability to generate knowledge through reflection and critical analysis, and personalize and assimilate health-related information into their lifestyle.

Comments regarding clarity and accuracy:

4. The learning process is facilitated by health professionals as they create a learning environment where, through dialogue, health care professionals and clients share knowledge and examine the clients' perception of reality regarding such aspects as the capability of the individual and the influence of society on health status.

Comments regarding clarity and accuracy:

5. As part of the learning process, health professionals facilitate and promote the clients connecting or linking with their internal and external components of learning, such as resources, information, and individual learning styles.

Comments regarding clarity and accuracy:

6. The empowering process has the potential to empower not only clients, but also enhance the empowerment of health professionals. Segments of society will also be impacted as clients and health professionals act upon their commitment to create healthy environments.

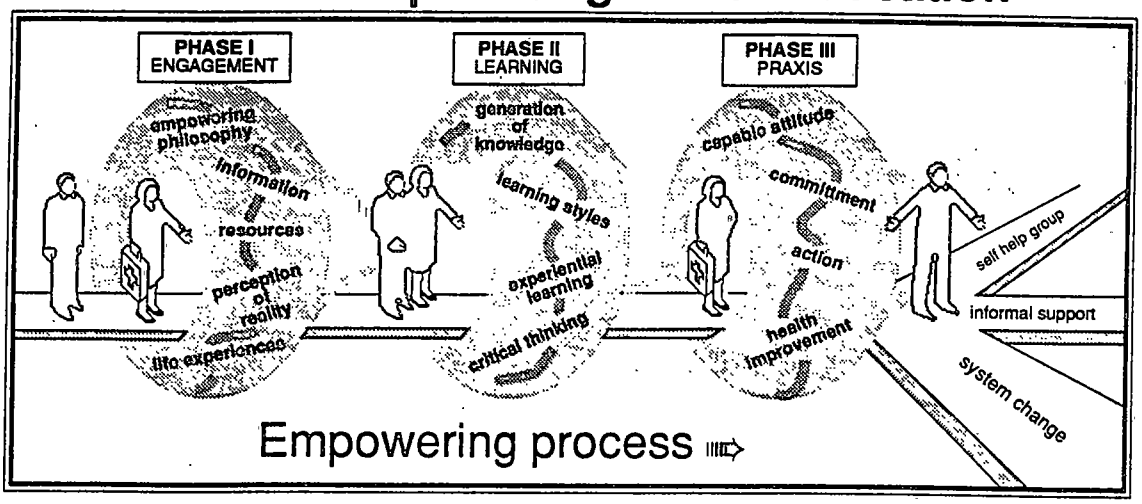
Comments regarding clarity and accuracy:

7. The health professionals' role is ultimately to foster the belief in clients that the clients can take control of the health-related factors influencing their lives and that their progress in achieving goals is the result of their actions and not those of the health professionals.

Comments regarding clarity and accuracy:

Overall Comments: Do the principles adequately and accurately represent the empowering approach to health education?

# Model of Empowering Health Education




Does the model reflect the principles?

Does the design of the model appropriately represent empowering health education?

# VI. EMPOWERING HEALTH EDUCATION MODEL

## INTRODUCTION

This model represents an empowerment approach to health education. The three phases represent various developmental stages of empowering health education that ultimately impacts the clients, health professionals, and society. The linking or connecting with various external and internal components of learning is an important aspect of this model and reflects the access to resources, power, and skills. A brief description of each phase is given.

### Phase I

This phase is important is setting the philosophical bases for the interaction. The empowering approach translates to honoring and respecting clients, dialoguing with the clients, reflecting on life experiences, introducing the experiential aspect of learning, suggesting societal resources and referrals, and assessing and reflecting on the client's perception of reality. It is a time for clients to present to the health educators their perception of their health status and life situation. Health professionals are seen as facilitators in this phase as they place primary responsibility for the learning with the clients while introducing the many aspects of health education.

### Phase II

This phase is characterized by experiential learning as clients discover their individualistic approaches to learning. They learn how to reflect and think critically about experiences and context, thereby generating important knowledge about themselves and their environment. Information from external sources is personalized and assimilated into their lifestyles. Through experiences and action, people begin to gain a sense of control, direction, and power, realizing the importance of accepting the responsibility for their health. People learn to connect to important and revealing information sources, power sources, and learning strategies. Health professionals are seen as mentors through this phase as they guide and support clients.

### Phase III

Commitment and proactive action emerge at this phase as clients develop a sense that they are responsible for the environment in which they live and often create spaces where they and others can experience healthier lives. They understand their potential impact on the immediate environment and larger society. Their attitude is one of "I can do!" because it is clear to the clients that they were the principle players in the health education process since they took credit for their

learning process. They understand their power, its sources, and its uses. Professionals gain valuable experiences and renews their commitment to the people and the process. Society is impacted on many levels by the empowering process. Health professionals are seen as resources in this phase.

# APPENDIX B

## NATIONAL JURY OF EXPERTS FOR DETERMINING VALIDITY FOR THEORETICAL FRAMEWORK

National Jury of Experts

| Name | Institution |
|---|---|
| Adult Educators: | |
| Dr. Hal Beder | Rutgers University, NJ |
| Dr. Phyllis Cunningham | Northern Illinois University, IL |
| Dr. Chere Gibson | University of Wisconsin-Madison, WI |
| Helen Lewis | Highlander, TN |
| Dr. Burt Sisco | University of Wyoming, WY |
| Connie White | Center for Literacy Studies, TN |
| Health Educators: | |
| Dr. Cheryl Achterberg | Pennsylvania State University, PA |
| Dr. Phillip Clark | University of Rhode Island, RI |
| Dr. Carl Dunst | Center for Family Studies, NC |
| Dr. Nancy Rody | University of Nevada, NV |
| Dr. Carol Trivette | Center for Family Studies, NC |
| Dr. Nina Wallerstein | University of New Mexico, NM |
| Bonnie Wesorick | Butterworth Hospital, MI |

# APPENDIX C

## COVER LETTER AND INSTRUCTIONS TO JURY OF EXPERTS FOR THEORETICAL FRAMEWORK

Dear _____,

Again, I want to thank you for agreeing to serve as a member of the jury of experts necessary for my research. Your understanding of empowerment is imperative in contributing to the validation of my study and I sincerely appreciate your time and thoughtfulness.

As I mentioned over the phone, my dissertation is a methodology study that examines empowering health education principles and practice. Ultimately, the purpose of this undertaking is to present the significance of the empowerment philosophy to the field of health education as an alternative to the paternalistic model still prevalent today. The scope of my dissertation includes developing a model of empowering health education which will help conceptualize the empowerment process and then creating an instrument to assess health professional's use of empowering strategies with clients. This instrument will be useful for self-assessment and reflection on practice.

Your responsibility at this point in the research is determining the initial phases of content and construct validity by assessing whether the model is relevant to the field and whether it is an accurate and complete representation of empowerment in health education practice. Please accomplish this by first **reviewing and commenting** on the following information provided to serve as a framework from which to consider the model:

I) synopsis of empowering health education,
II) working definition of empowerment,
III) goal of empowerment,
IV) set of assumptions.

Next, **critique** the principles (V), the guiding tenets for the model, for significance and clarity. Then please **determine** if the model reflects the principles. The brief narrative (VI) accompanying the model is for descriptive and clarification purposes. Finally, **comment** on the design of the model, i.e., does it appropriately represent empowering health education. Suggestions for clarification and improvement on any aspect of this validation phase are welcome. I would appreciate receiving your critique by March 29, 1991.

Sincerely,

Lynn Paul
P.O. Box 5217
Bozeman, MT 59717
W-(406) 994-6034
H-(406) 586-9582

# APPENDIX D

## NATIONAL JURY OF EXPERTS FOR DETERMINING VALIDITY OF INSTRUMENT

National Jury of Experts

| Name | Institution |
|---|---|
| Dr. Phillip Clark | University of Rhode Island, RI |
| Dr. Carl Dunst | Center for Family Studies, NC |
| Dr. Nancy Rody | University of Nevada, NV |
| Dr. Carol Trivette | Center for Family Studies, NC |

# APPENDIX E

## COVER LETTER, INSTRUCTIONS, PRINCIPLES AND STRATEGIES FOR DETERMINING VALIDITY OF INSTRUMENT

Thank you once again for your assistance. As I have previously mentioned, my research encompasses creating a conceptual framework of empowering health education and developing an instrument for health professionals to assess their use of empowerment strategies. At this point, I have completed the conceptual framework and have generated items for the instrument based on the eight principles developed for the conceptual framework.

The next step, with your assistance, will be establishing content validity for the instrument with your assistance. I am requesting that you assess whether the items generated from each principle fully operationalize the principle's content. Please also comment regarding item wording, item usefulness and relevancy, and any other areas. In the first principle, I have included the directions for the completing the instrument and Likert scale so you would be familiar with the format. Once the content validity is established, I will then pilot and field test the instrument.

Please call if you have any questions. I can be reached at my work number (406) 994-5702 or my home number (406) 586-9582 from 12/16/91-12/23/91 and then again on 12/30/91. I can be reached at (717) 629-1597 from 12/24/91-12/29/91. As I mentioned during our telephone conversation, I hope you would have time to complete this in the next two to three weeks.

Thank you again and have a very peaceful holiday season.

Sincerely,

Lynn Paul, M.S., R.D.

1. ESTABLISHING THE FRAMEWORK FOR INTERACTION

Health care professionals will acknowledge their personal working philosophy, promote dialogue and critical thinking, and create a caring, respectful environment for interaction.

PLEASE IDENTIFY WHICH NUMBER BEST DESCRIBES HOW FREQUENTLY YOU USE THE FOLLOWING STRATEGIES WHILE INTERACTING WITH HEALTH CARE CLIENTELE. REFERENCE TO THE CLIENTELE CAN BE EITHER WITH GROUPS OR INDIVIDUALS.

NEVER USE 1 2 3 4 5 ALWAYS USE

WITH EVERY HEALTH CARE CONSUMER....

___ 1. I discuss the health education philosophy that guides my practice.

___ 2. I provide a written copy of the health care principles that guide my practice.

___ 3. I consider discussions of health care philosophy of minor importance.

___ 4. I respect their vocabulary and manner of expression.

___ 5. I correct their health-related language.(-) **

___ 6. I dominate the discussions during the sessions.(-)

___ 7. I encourage them to question their assumptions of the cause of their health problems.

___ 8. I ask them what role they see themselves playing in their health care.

___ 9. I point out that each person is a unique individual and should be treated as an individual.

___10. I believe they would rather accept the conventional health care beliefs rather than think critically about health care.(-)

DO THE ITEMS FULLY OPERATIONALIZE THE CONTENT OF THE PRINCIPLE?

OTHER COMMENTS: (WORDING, BEST AND WORST ITEMS DESIGNATED BY + OR -)

** Items are negatively worded.

2. CONSUMER AS PRIMARY DECISION-MAKER

Participants are the primary decision-makers and are optimally in control as they define their problems, set goals, and generate solutions with full support from the health professional.

WITH EVERY HEALTH CARE CONSUMER....

___ 1. I assume they will be passive in their health care.(-)

___ 2. I assume that I will take the lead in planning their health care.(-)

___ 3. I take the lead in solving their problems.(-)

___ 4. I assume they prefer that I direct their health care.(-)

___ 5. I make most of the decisions regarding their health care.(-)

___ 6. I repeatedly say "This is your decision."

___ 7. I feel responsible for solving their health-related problems.(-)

___ 8. I ask them to tell me when they feel I take control of their health care.

___ 9. I try to convince them of the importance of medically- recognized concerns, if their concerns differ.(-)

___10. I directly ask "How may I help you?"

___11. I give examples on how they can develop their ability to take charge of their health care.

___12. I believe they want to be told what to do rather than be involved in decisions about their health care.(-)

___13. I ask questions that help them define their health care problems more clearly.

___14. I help them clarify alternative solutions so they can choose the solution they prefer.

___15. I encourage them to write down for themselves the goals and timelines for their health care management.

___16. I provide them with written directions and timelines for the practices I have recommended.(-)

___17. I make sure they understand why certain health care practices are recommended.

DO THE ITEMS FULLY OPERATIONALIZE THE CONTENT OF THE PRINCIPLE?

OTHER COMMENTS: (WORDING, BEST AND WORST ITEMS DESIGNATED BY + OR -)

3. PERSONALIZED, CONTEXTUALLY-BASED, EXPERIENTIAL LEARNING

Participants engage in a process of learning whereby they enhance their ability to generate knowledge through reflection upon their experiences, and personalize health-related information based on the context of their lives.

WITH EVERY HEALTH CARE CONSUMER....

___ 1. I give examples on how individuals meet their health care needs in very different ways.

___ 2. I expect most people have similar ways of solving their health problems.(-)

___ 3. I give examples on how emotional, intellectual, physical, spiritual, and social factors have an impact on achieving health goals.

___ 4. I describe the potentially slow and gradual nature of health-related change.

___ 5. I address the emotional difficulty of learning through experience.

___ 6. I demonstrate how one can generate knowledge by reflecting upon their health-related experiences.

___ 7. I explain the importance of the learning through experience, especially if they are unaccustomed to this type learning.

___ 8. I help them identify opportunities for generating beneficial knowledge.

___ 9. I emphasize that health-related knowledge results from reflecting on life experiences and is not just gained in health care interactions.

___10. I assume that with the necessary health information, the consumers will be able to adopt new behaviors without addressing behavior change specifically.(-)

___11. I see my role as an information-giver rather than a facilitator of learning.(-)

___12. I give examples of how health care practices vary in usefulness for people based upon their individual lives.

___13. I find out enough about their personal environments to make discussions fit the context of their lives.

___14. I fear they will take the easiest way available to deal with health problems.(-)

___15. I give them printed materials that give specific directions for care of each type of health problem commonly encountered.(-)

DO THE ITEMS FULLY OPERATIONALIZE THE CONTENT OF THE PRINCIPLE?

OTHER COMMENTS: (WORDING, BEST AND WORST ITEMS DESIGNATED BY + OR -)

4. BUILDING UPON SKILLS AND STRENGTHS

Health professionals will assist the consumer in building upon their existing skills, strengths, and behaviors in order to achieve their health-related goals and become more independent of the health care system.

WITH EVERY HEALTH CARE CONSUMER....

___ 1. I encourage them to articulate what behaviors and skills they think are necessary in order to be healthy.

___ 2. I assist them in identifying the skills they need to acquire in order to achieve their goals.

___ 3. I help them identify what skills they have already developed.

___ 4. I explain that health-related skill development may take time and effort.

___ 5. I tell them what skills are required for managing their health problems.(-)

___ 6. I assume that acquiring the skills they need to improve their health will be a priority in their lives.(-)

___ 7. I think it is important to acknowledge how they have successfully managed their health problem.

___ 8. I strongly encourage them to keep in touch regarding the progress of their health care management.

DO THE ITEMS FULLY OPERATIONALIZE THE CONTENT OF THE PRINCIPLE?

OTHER COMMENTS: (WORDING, BEST AND WORST ITEMS DESIGNATED BY + OR -)

5. CONSUMERS' DEVELOPMENT OF CONFIDENCE AND EMPOWERING PERSPECTIVE

The health professional's role is to foster the belief in consumers that they are capable of taking greater control of the health-related factors influencing their lives and that progress in achieving goals is the result of the participants' actions and not those of the health professionals or health program.

WITH EVERY HEALTH CARE CONSUMER....

___ 1. I provide non-threatening opportunities for self-assessment of their progress in achieving their goals.

___ 2. I make sure that acknowledgment of their progress is attributed to them and not health professionals or health programs.

___ 3. I help them develop confidence in their ability to change the factors negatively influencing their health.

___ 4. I help them develop confidence by acknowledging the positive things they have achieved.

___ 5. I provide opportunities for them to identify the successful steps they have taken.

___ 6. I encourage them to identify the problems encountered with not having control of their health care.

___ 7. I encourage them to identify the benefits of taking control of their health care.

___ 8. I feel confident of my program and abilities when they achieve their goals.(-)

___ 9. I spend most of the session emphasizing where they need to improve in order to achieve improved health status.(-)

___10. I make sure they understand how difficult it can be to cure and/or manage health problems.

___11. I explain that they very fact they recognize their health problems and have sought help means they are already making progress.

DO THE ITEMS FULLY OPERATIONALIZE THE CONTENT OF THE PRINCIPLE?

OTHER COMMENTS: (WORDING, BEST AND WORST ITEMS DESIGNATED BY + OR -)

6. PROFESSIONALS FACILITATE LINKAGE WITH RESOURCES

Health professionals facilitate the consumers linking with comprehensive and relevant array of resources, such as technical information, support groups, structural and system information, and information acquisition.

WITH EVERY HEALTH CARE CONSUMER....

___ 1. I help them identify what type of support they need to achieve their goals.

___ 2. I assist them in matching their needs to services and resources.

___ 3. I encourage them to create resources that will address their problem.

___ 4. I suggest resources that will assist them in acquiring a broad range of knowledge about their health problem and management.

___ 5. I emphasize the advantages of becoming aware of a wide variety of resources.

___ 6. I explain the advantages of seeking out others with the same health problem.

___ 7. I explain the importance of feeling in control of researching their health issues.

___ 8. I provide all the information they need in order to achieve their health goals.(-)

___ 9. I assume they will seek out other resources or ask me if they need additional help.(-)

___10. I deal with resources by providing a list of all the reliable referrals and resources pertaining to their problem.(-)

___11. I discuss ways of distinguishing between reliable and biased information.

___12. I help them understand health terminology that could confuse them.

DO THE ITEMS FULLY OPERATIONALIZE THE CONTENT OF THE PRINCIPLE?

OTHER COMMENTS: (WORDING, BEST AND WORST ITEMS DESIGNATED BY + OR -)

7. INFLUENCES OF SOCIAL, POLITICAL, ECONOMIC ENVIRONMENTS

The health professional will assist the consumer in assessing the social, political, and economic factors affecting their health status and discuss ways in which to impact and/or gain control of the factors.

WITH EVERY HEALTH CARE CONSUMER....

__ 1. I encourage them to identify how politics affects their health problems.

___ 2. I help the consumer recognize their ability to influence the societal causes of their health problem.

___ 3. I help them identify areas where they could positively influence general health practices.

___ 4. I discuss their beliefs about the importance of influences other than those that are individually-controlled on their health problems.

___ 5. I help them understand the limitations imposed by agencies' policies that may prevent them from obtaining all their goals.

___ 6. I provide examples of how their health issues are influenced by many social factors.

___ 7. I enable them to analyze the social factors influencing their health behavior.

___ 8. I help them realize that many health-related problems are shared by many, making them social problems.

___ 9. I help them realize that many health problems could be solved through the joint efforts of people who share the same concerns.

___ 10. I assume they are not interested in how politics affects their health problem.(-)

___ 11. I address their individual problem and do not relate it to social influences.(-)

___ 12. I do not see it as part of my job to address the social influences of their health problem.(-)

___ 13. I see my job as personal service to clients, not as a social reformer.(-)

___ 14. I discuss how economics has a major influence on health care problems.

DO THE ITEMS FULLY OPERATIONALIZE THE CONTENT OF THE PRINCIPLE?

OTHER COMMENTS: (WORDING, BEST AND WORST ITEMS DESIGNATED BY + OR -)

8. PROFESSIONAL'S COMMITMENT TO ADVANCING EMPOWERMENT IN HEALTH

The health professional will advocate for improving health-related environments in the areas identified by reflecting upon their practice, and the policies and activities of their profession, the health care system, and society.

WITH EVERY HEALTH CARE CONSUMER....

___ 1. I am alert for opportunities to learn from them.

___ 2. I ask them to evaluate my effectiveness in helping them achieve their health-related goals.

___ 3. I do not learn a great deal from them.(-)

___ 4. I appreciate how I benefit from my interactions with the consumer.

___ 5. I realize how our interactions are mutually beneficial.

___ 6. I create opportunities to learn how best to support them in the context of their lives.

---

___ 1. I advocate for the use of a philosophy of empowerment in sectors within society that impact the health status of consumers.

___ 2. I advance my competency as a professional by reflecting upon the outcome my actions.

___ 3. I create professionally-based knowledge by reflecting upon my practice.

___ 4. I discuss with colleagues the negative outcomes of poor health education practices that are commonly followed.

___ 5. I advance my professional competence by keeping current with technical information.(-)

___ 6. I advocate the need to address the social influences affecting health.

___ 7. I speak out publicly on political and social issues related to health care.

___ 8. I am an active advocate in a professional organization on issues related to relevant health care.

___ 9. I believe the major role of professional organizations should be to keep members up to date technologically.(-)

DO THE ITEMS FULLY OPERATIONALIZE THE CONTENT OF THE PRINCIPLE?

OTHER COMMENTS: (WORDING, BEST AND WORST ITEMS DESIGNATED BY + OR -)

## PRINCIPLES OF EMPOWERING HEALTH CARE FOR HEALTH CARE PROFESSIONALS

### 1. ESTABLISHING THE FRAMEWORK FOR INTERACTION

Health care professionals will acknowledge their personal working philosophy, promote dialogue and critical thinking, and create a caring, respectful environment for interaction.

### 2. CONSUMER AS PRIMARY DECISION-MAKER

Participants are the primary decision-makers and are optimally in control as they define their problems, set goals, and generate solutions with full support from the health professional.

### 3. PERSONALIZED, CONTEXTUALLY-BASED, EXPERIENTIAL LEARNING

Participants engage in a process of learning whereby they enhance their ability to generate knowledge through reflection upon their experiences, and personalize health-related information based on the context of their lives.

### 4. BUILDING UPON SKILLS AND STRENGTHS

Health professionals will assist the consumer in building upon their existing skills, strengths, and behaviors in order to achieve their health-related goals and become more independent of the health care system.

### 5. CONSUMERS' DEVELOPMENT OF CONFIDENCE AND EMPOWERING PERSPECTIVE

The health professional's role is to foster the belief in consumers that they are capable of taking greater control of the health-related factors influencing their lives and that progress in achieving goals is the result of the participants' actions and not those of the health professionals or health program.

### 6. PROFESSIONALS FACILITATE LINKAGE WITH RESOURCES

Health professionals facilitate the consumers linking with comprehensive and relevant array of resources, such as technical information, support groups, structural and system information, and information acquisition.

### 7. INFLUENCES OF SOCIAL, POLITICAL, ECONOMIC ENVIRONMENTS

The health professional will assist the consumer in assessing the social, political, and economic factors affecting their health status and discuss ways in which to impact and/or gain control of the factors.

### 8. PROFESSIONAL'S COMMITMENT TO ADVANCING EMPOWERMENT IN HEALTH

The health professional will advocate for improving health-related environments in the areas identified by reflecting upon their practice, and the policies and activities of their profession, the health care system, and society.

PLEASE IDENTIFY WHICH NUMBER BEST DESCRIBES HOW FREQUENTLY YOU USE THE FOLLOWING STRATEGIES WHILE INTERACTING WITH HEALTH CARE CLIENTELE. REFERENCE TO THE CLIENTELE CAN BE EITHER WITH INDIVIDUALS OR GROUPS.

NEVER USE 1 2 3 4 5 ALWAYS USE

WITH EVERY HEALTH CARE CONSUMER....

# APPENDIX F

## PILOT-TEST VERSION OF HEALTH EDUCATION STRATEGIES SCALE (HESS)

# Health Education Strategies Scale

Montana State University
Department of Education
Adult Learning and Education

MONTANA STATE UNIVERSITY

1992

MONTANA STATE UNIVERSITY
1893 • CENTENNIAL • 1993

**Department of Education**

College of Education, Health & Human Development
Unit of Curriculum & Instruction
Unit of Educational Leadership
Montana State University
Bozeman, MT 59717-0288

Telephone 406-994-3120

Dear Participant:

**Please read this page carefully before completing the questions.**

The strategies found in this instrument are intended to help us better understand how we educate health care clients. I have requested you to complete the instrument because of your experiences and insights in health education.

The development of this instrument is in partial fulfillment of my doctoral degree in Adult Learning and Education at Montana State University. The strategies found in this instrument have been reviewed by a national jury of experts in the fields of health care and adult education.

This is the pilot test version of the instrument so I am requesting that you complete each of the following items AND PLEASE ALSO LIBERALLY MAKE COMMENTS ABOUT WORDING, CLARITY, AND ANY OTHER SUGGESTIONS. I realize this version will be about twice the length of the final version.

All responses are confidential. The number that appears on the booklet identifies who has returned the instrument. Returning the instrument is regarded as your consent for participation.

PLEASE RETURN THE COMPLETED INSTRUMENT BY FRIDAY, FEBRUARY 30, 1992 using the pre-stamped envelope provided.

I realize the time constraints we all face, so I am very grateful for your time and effort in completing this instrument. I would be glad to share the results of this research with you and your coworkers.

Sincerely,

Lynn Paul

Lynn Paul, M.S., R.D.

**HEALTH EDUCATION STRATEGIES SCALE**
**(HESS)**

PLEASE CIRCLE THE NUMBER WHICH DESCRIBES HOW FREQUENTLY YOU USE THE FOLLOWING STRATEGIES WHILE EDUCATING HEALTH CARE CLIENTELE. CLIENTELE CAN BE EITHER WITH GROUPS OR INDIVIDUALS.

==========

WITH HEALTH CARE CLIENTELE .....

0 = NEVER USE
1 = SELDOM USE
2 = SOMETIMES USE
3 = FREQUENTLY USE
4 = ALWAYS USE

Q-1. I help them think about alternative solutions so they can choose the options they prefer ..... 0 1 2 3 4

Q-2. I give examples of how health education strategies may vary in their usefulness for different people ..... 0 1 2 3 4

Q-3. I help them develop confidence by acknowledging the positive things they have achieved ..... 0 1 2 3 4

Q-4. I discuss the skills and resources that are important for acquiring additional information about their health problems ..... 0 1 2 3 4

Q-5. I provide examples of how their health issues are influenced by social factors ..... 0 1 2 3 4

Q-6. I listen to see how I can collaborate with them to identify and resolve important health issues ..... 0 1 2 3 4

---

PLEASE ALSO COMMENT ON CLARITY OF WORDS OR STATEMENTS.

---

WITH HEALTH CARE CLIENTELE .....

0 = NEVER USE
1 = SELDOM USE
2 = SOMETIMES USE
3 = FREQUENTLY USE
4 = ALWAYS USE

Q-7. I help them think about the social factors influencing their health ..... 0 1 2 3 4

Q-8. I assist them in matching their needs to services and resources ..... 0 1 2 3 4

Q-9. I make sure that they acknowledge their part in achieving their goals ..... 0 1 2 3 4

Q-10. I help them identify what skills and strengths they already have in order to achieve their goals ..... 0 1 2 3 4

Q-11. I expect most people have similar ways of solving their health problems ..... 0 1 2 3 4

Q-12. I repeatedly say "This is your decision." ..... 0 1 2 3 4

Q-13. I respect their language and manner of expression ..... 0 1 2 3 4

Q-14. I fully support their decisions even if they are not what I would recommend ..... 0 1 2 3 4

Q-15. I adjust my style of teaching to match their style of learning ..... 0 1 2 3 4

Q-16. I explain that the very fact they recognize their health problems and have sought help means they are already making progress ..... 0 1 2 3 4

Q-17. I discuss the health education principles that guide my practice ..... 0 1 2 3 4

Q-18. I assume that I will take the lead in planning their health care ..... 0 1 2 3 4

Q-19. I give examples of how individuals meet their health care needs in very different ways ..... 0 1 2 3 4

WITH HEALTH CARE CLIENTELE .....

0 = NEVER USE
1 = SELDOM USE
2 = SOMETIMES USE
3 = FREQUENTLY USE
4 = ALWAYS USE

Q-20. I encourage them to think about what skills and strengths they need in order to be healthier ..... 0 1 2 3 4

Q-21. I provide opportunities for them to think about the progress they have made in achieving their goals ..... 0 1 2 3 4

Q-22. I help them identify what type of resources they need to achieve their goals ..... 0 1 2 3 4

Q-23. I help them recognize their ability to influence the socio-politico-economic causes of their health problem ..... 0 1 2 3 4

Q-24. I learn from their concerns ..... 0 1 2 3 4

Q-25. I make sure they understand why certain health care practices are recommended ..... 0 1 2 3 4

Q-26. I believe they would accept health professionals' recommendations without question rather than think critically or challenge my advice ..... 0 1 2 3 4

Q-27. I directly ask "How may I help you?" ..... 0 1 2 3 4

Q-28. I emphasize that health-related knowledge results from reflecting on life experiences and is not just gained in health care interactions ..... 0 1 2 3 4

Q-29. I help them realize how managing their health problems may take a variety of skills and abilities ..... 0 1 2 3 4

Q-30. I encourage them to identify the benefits of taking control of their health ..... 0 1 2 3 4

---

PLEASE ALSO COMMENT ON CLARITY OF WORDS OR STATEMENTS.

---

WITH HEALTH CARE CLIENTELE .....

0 = NEVER USE
1 = SELDOM USE
2 = SOMETIMES USE
3 = FREQUENTLY USE
4 = ALWAYS USE

| | | |
|---|---|---|
| Q-31. | I explain the advantages of getting support from others with the same health problem | 0 1 2 3 4 |
| Q-32. | I address their problem as an individual one and do not relate it to social influences | 0 1 2 3 4 |
| Q-33. | I ask myself to what extent my actions actually enhance their abilities to take charge of their health care or only add to their passivity | 0 1 2 3 4 |
| Q-34. | I do not learn a great deal from them | 0 1 2 3 4 |
| Q-35. | I help them realize that some health-related problems are shared by many people, making them social problems | 0 1 2 3 4 |
| Q-36. | I encourage them to develop sources of help that will address their problem if none currently exist | 0 1 2 3 4 |
| Q-37. | I help them develop confidence in their ability to change the factors affecting their health | 0 1 2 3 4 |
| Q-38. | I simply tell them what skills they need to manage their health problems | 0 1 2 3 4 |
| Q-39. | I explain the potential challenges of long-term behavior change | 0 1 2 3 4 |
| Q-40. | I feel responsible for solving their health-related problems | 0 1 2 3 4 |
| Q-41. | I do most of the talking during the health-care sessions | 0 1 2 3 4 |
| Q-42. | I consider discussion of health care philosophy of major importance | 0 1 2 3 4 |

WITH HEALTH CARE CLIENTELE .....

0 = NEVER USE
1 = SELDOM USE
2 = SOMETIMES USE
3 = FREQUENTLY USE
4 = ALWAYS USE

Q-43. I give examples on how they can take charge of their own health care ..... 0 1 2 3 4

Q-44. I assume factual information is enough to change their behavior ..... 0 1 2 3 4

Q-45. I think it is important to acknowledge how they have successfully managed their health problem ..... 0 1 2 3 4

Q-46. I spend most of the time emphasizing what they need to change for improved health status ..... 0 1 2 3 4

Q-47. I provide all the information they need to achieve their health goals ..... 0 1 2 3 4

Q-48. I see my job as addressing their individual problems and not relating them to larger issues ..... 0 1 2 3 4

Q-49. I model competencies necessary for gaining control over factors affecting my health. ..... 0 1 2 3 4

Q-50. I appreciate how I benefit from my interactions with them ..... 0 1 2 3 4

Q-51. I help them realize that many health problems could be solved through the joint efforts of people who share the same concerns ..... 0 1 2 3 4

Q-52. I suggest resources that will help them acquire additional information about their health problem and how to manage it ..... 0 1 2 3 4

Q-53. I provide opportunities for them to identify the successful steps they have already taken ..... 0 1 2 3 4

---

PLEASE ALSO COMMENT ON CLARITY OF WORDS OR STATEMENTS.

---

WITH HEALTH CARE CLIENTELE .....

0 = NEVER USE
1 = SELDOM USE
2 = SOMETIMES USE
3 = FREQUENTLY USE
4 = ALWAYS USE

Q-54. I assume that they give high priority to gaining health skills ..... 0 1 2 3 4

Q-55. I help them identify opportunities in their everyday experiences where they could learn more about how to better manage their health ..... 0 1 2 3 4

Q-56. I ask them to tell me when they feel I am taking charge of their health care ..... 0 1 2 3 4

Q-57. I ask them what role they see themselves and health care professionals playing in managing their health problems ..... 0 1 2 3 4

Q-58. I point out that each person is unique and health care should be personalized to meet their needs ..... 0 1 2 3 4

Q-59. I believe they want to be told what to do rather than be involved in decisions about their health care ..... 0 1 2 3 4

Q-60. I see my role as giving information rather than teaching how people can learn for themselves ..... 0 1 2 3 4

Q-61. I encourage learning skills that help them gain more independence in their abilities to manage their health ..... 0 1 2 3 4

Q-62. I discuss with them the ways they can take charge of circumstances affecting their health ..... 0 1 2 3 4

Q-63. I assume they will seek out other resources or ask me if they need additional help ..... 0 1 2 3 4

Q-64. I address how socio-politico-economic factors have a major influence on health care problems ..... 0 1 2 3 4

Q-65. I help them understand the limits created by agencies may prevent them from obtaining their goals ..... 0 1 2 3 4

WITH HEALTH CARE CLIENTELE ..... 0 = NEVER USE
1 = SELDOM USE
2 = SOMETIMES USE
3 = FREQUENTLY USE
4 = ALWAYS USE

Q-66. I stress the importance of their being responsible for seeking out additional resources and information ..... 0 1 2 3 4

Q-67. I can accept disagreements with the statements or strategies I recommend ..... 0 1 2 3 4

Q-68. I explain that learning health skills takes time and effort ..... 0 1 2 3 4

Q-69. I find out enough about their lives to make information relevant to them ..... 0 1 2 3 4

Q-70. I ask questions that help them clarify their health care problems ..... 0 1 2 3 4

Q-71. I see myself as a consultant to the consumer ..... 0 1 2 3 4

Q-72. I explain the importance of "learning by doing" with health concerns ..... 0 1 2 3 4

---

PLEASE ALSO COMMENT ON CLARITY OF WORDS OR STATEMENTS.

---

PLEASE IDENTIFY THE NUMBER WHICH BEST DESCRIBES HOW FREQUENTLY YOU USE THE FOLLOWING STRATEGIES WHILE INTERACTING WITH OTHER HEALTH CARE PROFESSIONALS AND PEOPLE WITHIN SOCIETY...

==========

WITH HEALTH CARE CLIENTELE ..... 0 = NEVER USE
1 = SELDOM USE
2 = SOMETIMES USE
3 = FREQUENTLY USE
4 = ALWAYS USE

Q-73. I discuss with colleagues the negative outcomes of poor health education practices ..... 0 1 2 3 4

Q-74. I advocate using the empowerment philosophy in segments of society that affect clienteles' health ..... 0 1 2 3 4

Q-75. I volunteer my service to community groups whose goal is improved health status ..... 0 1 2 3 4

Q-76. I see my role to direct the activities of community groups dealing with health issues ..... 0 1 2 3 4

Q-77. I speak out publicly on political and social issues related to health care ..... 0 1 2 3 4

Q-78. I believe the major role of professional organizations should be to keep members up-to-date technically ..... 0 1 2 3 4

Q-79. I advance my competency as a professional by reflecting upon the outcome of my actions ..... 0 1 2 3 4

COMMENTS/SUGGESTIONS FOR IMPROVEMENT:

WORDING?

CLARITY?

OTHER?

## INDIVIDUAL BACKGROUND

PLEASE CIRCLE THE MOST APPROPRIATE NUMBER OR FILL IN THE BLANK FOR EACH QUESTION.

==========

Q-80. In what year were you born? _____

Q-81. Your gender.

1 WOMAN
2 MAN

Q-82. Which of the following best describes your racial or ethnic identification?

1 CAUCASIAN/WHITE
2 NATIVE AMERICAN INDIAN
3 AFRO-AMERICAN
4 HISPANIC/MEXICAN AMERICAN
5 ASIAN AMERICAN
6 OTHER (please specify) _____

Q-83. What is your profession?

1 NURSING
2 DIETETICS
3 PHYSICAL THERAPY
4 OCCUPATIONAL THERAPY
5 HEALTH EDUCATION
6 PHARMACY
7 PHYSICIAN
8 OTHER (please specify) _____

Q-84. What is the highest degree you have earned?

1 HIGH SCHOOL DIPLOMA
2 GED
3 ASSOCIATE ARTS
4 BACHELOR
5 MASTERS
6 DOCTORAL
7 VOCATIONAL CERTIFICATION
8 NO DEGREE

Q-85. Do you have professional certification? (i.e. registered dietitian)

1 REGISTERED
2 LICENSED
3 PRACTITIONER
4 CERTIFIED
5 OTHER (please specify) _____

Q-86. How many hours a week do you work in your profession for pay and in volunteer service?

____HOURS PER WEEK

Q-87. How many hours a week do you average working in direct CLIENT/CONSUMER health-related education with individuals and groups?

____HOURS PER WEEK WITH INDIVIDUALS
____HOURS PER WEEK WITH GROUPS

Q-88. What is the practice setting where you have the majority of direct CLIENT/CONSUMER education?

1 HOSPITAL
2 HOSPITAL-BASED CLINIC
3 PRIVATE BUSINESS
4 HEALTH DEPARTMENT
5 STUDENT HEALTH SERVICE
6 NON-PROFIT CLINIC
7 FOR-PROFIT CLINIC
8 NURSING HOME

Q-89. How long have you been practicing in your profession?

____NUMBER OF YEARS

Q-90. How many years have you been involved with CLIENT/CONSUMER education?

____NUMBER OF YEARS

Q-91. In what county and zip code do you practice?

_____COUNTY _____ZIP CODE

A SINCERE THANK YOU!

# APPENDIX G

## FIELD-TEST VERSION OF HEALTH EDUCATION STRATEGIES SCALE (HESS)

# Health Education Strategies Scale

Montana State University
Department of Education
Center for Adult Learning

MONTANA STATE UNIVERSITY

1992

MONTANA STATE UNIVERSITY
1893 • CENTENNIAL • 1993

**Department of Education**

College of Education, Health & Human Development
Unit of Curriculum & Instruction
Unit of Educational Leadership
Montana State University
Bozeman, MT 59717-0288

Telephone 406-994-3120

Dear Participant:

Please read this page carefully before completing the questions.

The strategies found in this instrument are intended to help us better understand how we educate health care clients. I am asking you to complete the instrument because of your experiences and insights in health education.

The development of this instrument is in partial fulfillment of my doctoral degree in Adult Learning at Montana State University. The strategies found in this instrument have been reviewed by a national jury of experts in the fields of health care and adult education. This instrument has been pilot tested and the results analyzed.

This is the field test version of the instrument and averages **10 MINUTES TO COMPLETE.** The results of this field test will be the final analysis for my research with additional quantitative and qualitative research completed after receiving my degree.

All responses are confidential. The number that appears on the booklet will help identify who has returned the instrument and whom to contact in case additional clarification of responses is needed. Returning the instrument is regarded as your consent for participation.

PLEASE RETURN THE COMPLETED INSTRUMENT by the date we determined in our discussion using the pre-stamped envelope provided.

I realize the time constraints we all face, so I am very grateful for your time and effort in completing this instrument. I would be glad to share the results of this research with you and your coworkers. If you have questions, please call me at 586-9582 or write to me at P.O. Box 5217, Bozeman, MT, 59717.

Sincerely,

Lynn Paul

Lynn Paul, M.S., R.D.

## HEALTH EDUCATION STRATEGIES SCALE (HESS)

Directions: Please CIRCLE THE NUMBER which describes how FREQUENTLY you use the following STRATEGIES while EDUCATING health care clientele. Clientele can be either with groups or individuals.

==========

0 = NEVER
1 = SELDOM
2 = SOMETIMES
3 = FREQUENTLY
4 = ALWAYS

WITH HEALTH CARE CLIENTELE . . . . .

| | | |
|---|---|---|
| Q-1. | I give examples of how health education recommendations vary in their usefulness among people . . | 0 1 2 3 4 |
| Q-2. | I discuss the resources that are important for acquiring additional information about their health problems . . . . . | 0 1 2 3 4 |
| Q-3. | I provide examples of how their health issues are influenced by social factors . . . . . | 0 1 2 3 4 |
| Q-4. | I expect most people have similar ways of solving their health problems . . . . . | 0 1 2 3 4 |
| Q-5. | I help them think about the social factors influencing their health . . . . . | 0 1 2 3 4 |
| Q-6. | I assist them in matching their health care needs to services . . . . . | 0 1 2 3 4 |
| Q-7. | I encourage them to accept health professionals' recommendations without question rather than to think critically about that advice . . . . . | 0 1 2 3 4 |
| Q-8. | I make sure that they give credit to themselves for their contribution in achieving their goals . . . . . | 0 1 2 3 4 |
| Q-9. | I help them identify what abilities they already have in order to achieve their goals . . . . . | 0 1 2 3 4 |
| Q-10. | I repeatedly say, "This is your decision." . . . . . | 0 1 2 3 4 |

0 = NEVER
1 = SELDOM
2 = SOMETIMES
3 = FREQUENTLY
4 = ALWAYS

WITH HEALTH CARE CLIENTELE . . . . .

| | | | | | | |
|---|---|---|---|---|---|---|
| Q-11. | I fully support their decisions even if they are not what I would recommend . . . . . | 0 | 1 | 2 | 3 | 4 |
| Q-12. | I tell them what skills they need to manage their health problems . . . . . | 0 | 1 | 2 | 3 | 4 |
| Q-13. | I explain that seeking help for their health problems means they are already making progress . . . . . | 0 | 1 | 2 | 3 | 4 |
| Q-14. | I discuss the health education principles that guide my practice . . . . . | 0 | 1 | 2 | 3 | 4 |
| Q-15. | I help them recognize their ability to influence the social/political/economic causes of their health problem . . . . . | 0 | 1 | 2 | 3 | 4 |
| Q-16. | I take responsibility for solving their health-related problems . . . . . | 0 | 1 | 2 | 3 | 4 |
| Q-17. | I directly ask, "How may I help you?" . . . . . | 0 | 1 | 2 | 3 | 4 |
| Q-18. | I show how reflecting on life experiences results in health-related knowledge . . . . . | 0 | 1 | 2 | 3 | 4 |
| Q-19. | I help them realize how managing their health problems may take a variety of abilities . . . . . | 0 | 1 | 2 | 3 | 4 |
| Q-20. | I explain the advantages of getting support from others with the same health problem . . . . . | 0 | 1 | 2 | 3 | 4 |
| Q-21. | I ask myself to what extent my actions add to their passivity with their health care . . . . . | 0 | 1 | 2 | 3 | 4 |
| Q-22. | I do most of the talking during the health-care sessions . . . . . | 0 | 1 | 2 | 3 | 4 |
| Q-23. | I reflect on what I learn from them . . . . . | 0 | 1 | 2 | 3 | 4 |
| Q-24. | I help them realize that some health-related problems are shared by many people, thereby making them social problems . . . . . | 0 | 1 | 2 | 3 | 4 |

0 = NEVER
1 = SELDOM
2 = SOMETIMES
3 = FREQUENTLY
4 = ALWAYS

WITH HEALTH CARE CLIENTELE . . . . .

| | | |
|---|---|---|
| Q-25. | I assume factual information is enough to change their behavior . . . . . | 0 1 2 3 4 |
| Q-26. | I encourage them to develop resources that will address their problem if none currently exist . . . . . | 0 1 2 3 4 |
| Q-27. | I help them develop confidence in their ability to change the factors affecting their health . . . . . | 0 1 2 3 4 |
| Q-28. | I explain the potential challenges of long-term behavior change . . . . . | 0 1 2 3 4 |
| Q-29. | I give examples on how they can take charge of their own health care . . . . . | 0 1 2 3 4 |
| Q-30. | I acknowledge how they have successfully managed their health problems . . . . . | 0 1 2 3 4 |
| Q-31. | I spend most of the time emphasizing what they need to change for improved health status . . . . . | 0 1 2 3 4 |
| Q-32. | I provide all they need to achieve their health goals . . . . | 0 1 2 3 4 |
| Q-33. | I address their individual problems rather than relating those problems to larger social issues . . . . . | 0 1 2 3 4 |
| Q-34. | I help them realize that many health problems could be solved through the joint efforts of people who share the same concerns . . . . . | 0 1 2 3 4 |
| Q-35. | I provide opportunities for them to identify the successful steps they have already taken . . . . . | 0 1 2 3 4 |
| Q-36. | I make suggestions assuming they give high priority to gaining health skills . . . . . | 0 1 2 3 4 |
| Q-37. | I ask them to tell me when they feel I am taking the responsibility for their health care away from them . . . . | 0 1 2 3 4 |
| Q-38. | I ask them what roles they see themselves and their health care professionals playing in managing their health problems . . . . . | 0 1 2 3 4 |

0 = NEVER
1 = SELDOM
2 = SOMETIMES
3 = FREQUENTLY
4 = ALWAYS

WITH HEALTH CARE CLIENTELE . . . . .

Q-39. I point out that because each person is unique, health care should be personalized to meet their needs . . . . . 0 1 2 3 4

Q-40. I spend time giving information rather than teaching them how they can learn for themselves . . . . . 0 1 2 3 4

Q-41. I encourage developing skills that increase their independence in managing their health . . . . . 0 1 2 3 4

Q-42. I stress the importance of them being responsible for seeking out additional resources . . . . . 0 1 2 3 4

Q-43. I accept disagreements with the statements or strategies I recommend . . . . . 0 1 2 3 4

Q-44. I find out enough about their lives to make information relevant to them . . . . . 0 1 2 3 4

Please IDENTIFY the number which best describes how FREQUENTLY you use the following strategies while INTERACTING WITH OTHER HEALTH CARE PROFESSIONALS AND PEOPLE WITHIN SOCIETY.

==========

0 = NEVER
1 = SELDOM
2 = SOMETIMES
3 = FREQUENTLY
4 = ALWAYS

Q-45. I discuss with colleagues the negative outcomes of poor health education practices . . . . . 0 1 2 3 4

Q-46. I advocate using the empowerment philosophy in any area of society that affect a client's health . . . . . 0 1 2 3 4

Q-47. I volunteer my service to community groups that strive for improved health status . . . . . 0 1 2 3 4

Q-48. I support the assumption that the major role of professional organizations is to keep members up-to-date technically . . . . . 0 1 2 3 4

Q-49. I speak out publicly on political and social issues related to health care . . . . . 0 1 2 3 4

## INDIVIDUAL BACKGROUND

Please circle the most appropriate number or fill in the blank for each question.

==========

Q-50. In what year were you born? _____

Q-51. Your gender.

1 WOMAN
2 MAN

Q-52. Which of the following best describes your racial or ethnic identification?

1 CAUCASIAN/WHITE
2 NATIVE AMERICAN INDIAN
3 AFRO-AMERICAN
4 HISPANIC/MEXICAN AMERICAN
5 ASIAN AMERICAN
6 OTHER (please specify) _____

Q-53. What is your profession?

1 NURSING
2 DIETETICS
3 PHYSICAL THERAPY
4 OCCUPATIONAL THERAPY
5 HEALTH EDUCATION
6 PHARMACY
7 PHYSICIAN
8 OTHER (please specify) _____

Q-54. What is the highest degree you have earned?

1 HIGH SCHOOL DIPLOMA
2 GED
3 ASSOCIATE ARTS
4 BACHELOR
5 MASTERS
6 DOCTORAL
7 VOCATIONAL CERTIFICATION
8 NO DEGREE

Please turn page →

Q-55. How many hours a week do you work in your profession for pay and in volunteer service?

_____HOURS PER WEEK

Q-56. How many hours a week do you average working in direct CLIENT/CONSUMER health-related education with individuals and groups?

_____HOURS PER WEEK WITH INDIVIDUALS
_____HOURS PER WEEK WITH GROUPS

Q-57. What is the practice setting where you have the majority of direct CLIENT/CONSUMER education?

1 HOSPITAL
2 HOSPITAL-BASED CLINIC
3 PRIVATE BUSINESS
4 HEALTH DEPARTMENT
5 STUDENT HEALTH SERVICE
6 NON-PROFIT CLINIC
7 FOR-PROFIT CLINIC
8 NURSING HOME
9 OTHER (please specify) _____

Q-58. How long have you been practicing in your profession?

_____NUMBER OF YEARS

Q-59. How many years have you been involved with CLIENT/CONSUMER education?

_____NUMBER OF YEARS

Q-60. In what county and zip code do you practice?

_____COUNTY _____ZIP CODE

A SINCERE THANK YOU!

# APPENDIX H

## FINAL VERSION OF
## HEALTH EDUCATION STRATEGIES SCALE (HESS)

# Health Education Strategies Scale

Montana State University
Department of Education
Center for Adult Learning


1992

## HEALTH EDUCATION STRATEGIES SCALE (HESS)

Directions: Please CIRCLE THE NUMBER which describes how FREQUENTLY you use the following STRATEGIES while EDUCATING health care clientele. Clientele can be either with groups or individuals.

==========

0 = NEVER
1 = SELDOM
2 = SOMETIMES
3 = FREQUENTLY
4 = ALWAYS

WITH HEALTH CARE CLIENTELE .....

| | | | | | | |
|---|---|---|---|---|---|---|
| Q-1. | I give examples of how health education recommendations vary in their usefulness among people .. | 0 | 1 | 2 | 3 | 4 |
| Q-2. | I discuss the resources that are important for acquiring additional information about their health problems ..... | 0 | 1 | 2 | 3 | 4 |
| Q-3. | I provide examples of how their health issues are influenced by social factors ..... | 0 | 1 | 2 | 3 | 4 |
| Q-4. | I help them think about the social factors influencing their health ..... | 0 | 1 | 2 | 3 | 4 |
| Q-5. | I assist them in matching their health care needs to services ..... | 0 | 1 | 2 | 3 | 4 |
| Q-6. | I encourage them to accept health professionals' recommendations without question rather than to think critically about that advice ..... | 0 | 1 | 2 | 3 | 4 |
| Q-7. | I make sure that they give credit to themselves for their contribution in achieving their goals ..... | 0 | 1 | 2 | 3 | 4 |
| Q-8. | I help them identify what abilities they already have in order to achieve their goals ..... | 0 | 1 | 2 | 3 | 4 |
| Q-9. | I repeatedly say, "This is your decision." ..... | 0 | 1 | 2 | 3 | 4 |

0 = NEVER
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2 = SOMETIMES
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4 = ALWAYS

WITH HEALTH CARE CLIENTELE .....

| | | | | | | |
|---|---|---|---|---|---|---|
| Q-10. | I fully support their decisions even if they are not what I would recommend ..... | 0 | 1 | 2 | 3 | 4 |
| Q-11. | I explain that seeking help for their health problems means they are already making progress ..... | 0 | 1 | 2 | 3 | 4 |
| Q-12. | I discuss the health education principles that guide my practice ..... | 0 | 1 | 2 | 3 | 4 |
| Q-13. | I help them recognize their ability to influence the social/political/economic causes of their health problem ..... | 0 | 1 | 2 | 3 | 4 |
| Q-14. | I directly ask, "How may I help you?" ..... | 0 | 1 | 2 | 3 | 4 |
| Q-15. | I show how reflecting on life experiences results in health-related knowledge ..... | 0 | 1 | 2 | 3 | 4 |
| Q-16. | I help them realize how managing their health problems may take a variety of abilities ..... | 0 | 1 | 2 | 3 | 4 |
| Q-17. | I explain the advantages of getting support from others with the same health problem ..... | 0 | 1 | 2 | 3 | 4 |
| Q-18. | I ask myself to what extent my actions add to their passivity with their health care ..... | 0 | 1 | 2 | 3 | 4 |
| Q-19. | I do most of the talking during the health-care sessions ..... | 0 | 1 | 2 | 3 | 4 |
| Q-20. | I reflect on what I learn from them ..... | 0 | 1 | 2 | 3 | 4 |
| Q-21. | I help them realize that some health-related problems are shared by many people, thereby making them social problems ..... | 0 | 1 | 2 | 3 | 4 |
| Q-22. | I assume factual information is enough to change their behavior ..... | 0 | 1 | 2 | 3 | 4 |

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3 = FREQUENTLY
4 = ALWAYS

WITH HEALTH CARE CLIENTELE . . . . . .

| | | | | | | |
|---|---|---|---|---|---|---|
| Q-23. | I encourage them to develop resources that will address their problem if none currently exist . . . . . | 0 | 1 | 2 | 3 | 4 |
| Q-24. | I help them develop confidence in their ability to change the factors affecting their health . . . . . | 0 | 1 | 2 | 3 | 4 |
| Q-25. | I explain the potential challenges of long-term behavior change . . . . . | 0 | 1 | 2 | 3 | 4 |
| Q-26. | I give examples on how they can take charge of their own health care . . . . . | 0 | 1 | 2 | 3 | 4 |
| Q-27. | I acknowledge how they have successfully managed their health problems . . . . . | 0 | 1 | 2 | 3 | 4 |
| Q-28. | I spend most of the time emphasizing what they need to change for improved health status . . . . . | 0 | 1 | 2 | 3 | 4 |
| Q-29. | I help them realize that many health problems could be solved through the joint efforts of people who share the same concerns . . . . . | 0 | 1 | 2 | 3 | 4 |
| Q-30. | I provide opportunities for them to identify the successful steps they have already taken . . . . . | 0 | 1 | 2 | 3 | 4 |
| Q-31. | I make suggestions assuming they give high priority to gaining health skills . . . . . | 0 | 1 | 2 | 3 | 4 |
| Q-32. | I ask them to tell me when they feel I am taking the responsibility for their health care away from them . . . . | 0 | 1 | 2 | 3 | 4 |
| Q-33. | I ask them what roles they see themselves and their health care professionals playing in managing their health problems . . . . . | 0 | 1 | 2 | 3 | 4 |
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Q-37. I stress the importance of them being responsible for seeking out additional resources . . . . . 0 1 2 3 4

Q-38. I accept disagreements with the statements or strategies I recommend . . . . . 0 1 2 3 4

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Q-42. I volunteer my service to community groups that strive for improved health status . . . . . 0 1 2 3 4

Q-43. I speak out publicly on political and social issues related to health care . . . . . 0 1 2 3 4

## INDIVIDUAL BACKGROUND

Please circle the most appropriate number or fill in the blank for each question.

==========

Q-44. In what year were you born? _____

Q-45. Your gender.

1 WOMAN
2 MAN

Q-46. Which of the following best describes your racial or ethnic identification?

1 CAUCASIAN/WHITE
2 NATIVE AMERICAN INDIAN
3 AFRO-AMERICAN
4 HISPANIC/MEXICAN AMERICAN
5 ASIAN AMERICAN
6 OTHER (please specify) _____

Q-47. What is your profession?

1 NURSING
2 DIETETICS
3 PHYSICAL THERAPY
4 OCCUPATIONAL THERAPY
5 HEALTH EDUCATION
6 PHARMACY
7 PHYSICIAN
8 OTHER (please specify) _____

Q-48. What is the highest degree you have earned?

1 HIGH SCHOOL DIPLOMA
2 GED
3 ASSOCIATE ARTS
4 BACHELOR
5 MASTERS
6 DOCTORAL
7 VOCATIONAL CERTIFICATION
8 NO DEGREE

Please turn page →

Q-49. How many hours a week do you work in your profession for pay and in volunteer service?

_____HOURS PER WEEK

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6 NON-PROFIT CLINIC
7 FOR-PROFIT CLINIC
8 NURSING HOME
9 OTHER (please specify) _____

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_____NUMBER OF YEARS

Q-53. How many years have you been involved with CLIENT/CONSUMER education?

_____NUMBER OF YEARS

Q-54. In what county and zip code do you practice?

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A SINCERE THANK YOU!