Understanding

Personal, Social, Health Economic Education Primary Schools

Nick Boddington | Adrian King | Jenny McWhirter

SAGE

UNDERSTANDING EFFECTIVE PRACTICE IN PSHE EDUCATION

Aim

To introduce ten principles for effective practice in PSHE education.
   This chapter is structured around a series of questions, all of which are intended to help you understand effective approaches to teaching and learning in PSHE education.

Learning objectives

By reading and reflecting on the content of this chapter you will:

- know the rationale underpinning effective approaches to PSHE education
- understand why some approaches are more effective than others
- be able to take account of the ten principles for effective PSHE education in your planning
- be able to create opportunities for your pupils to take decisions which will enable them to act on their intentions.

Getting started

This chapter reviews theories and some of the evidence underpinning the ten guiding principles of effective practice in PSHE education.

> **Consider**
>
> Before reading this chapter ask yourself where your own understanding of effective teaching and learning comes from. What key principles guide your practice in the primary school classroom? The similarities and differences between effective primary practice and effective PSHE education may surprise and, we hope, reassure you.

What do we need to know about children and young people to teach PSHE education effectively?

There are many theories of teaching and learning, all of which rely on an understanding of how children and young people develop, cognitively, morally and socially (see Berk, 2007; Gray and MacBlain, 2012; Gross, 2010; Muijs and Reynolds, 2011, for more detailed discussion of child development). Theories of child and adolescent development also have some basis in the development of the human brain and the extent to which that development is predetermined (nature) or shaped by experience (nurture) (Battro et al., 2008). Drawing on these sources, in this section we consider how our knowledge and understanding of child development has helped to shape PSHE education practice in the last 20 years.

What is learning?

According to the PSHE Association's definition, learning is the process through which 'children and young people acquire the knowledge, understanding and skills they need to manage their lives, now and in the future' (PSHE Association, 2013).

Some authors define learning more narrowly in terms of knowledge and skills (Gray and MacBlain, 2012: 2) while others define learning in terms of behaviour change (see Gross, 1996: 155). Whether learning should be defined in terms of behaviour change is an important question

which goes to the heart of teaching and learning in PSHE education. We have already argued in Chapter 1 that PSHE education does not set out to predetermine the decisions children may make, or the behaviours they may adopt. Your view on this will almost certainly influence how you approach teaching and learning in your PSHE education lessons.

Consider

It is readily acknowledged that smoking tobacco is bad for our health. The rates of smoking among adults have been falling steadily over the last 20 years, but once other factors are accounted for, girls are more likely to report being smokers than boys (Gill et al., 2012). More women are developing lung cancer than ever before (Cancer Research UK, 2012). Our education about smoking provides children with an understanding of the physical and psychological effects of smoking, the financial cost, knowledge about who smokes and why, skills to identify and resist influence and pressure to become a smoker, supported by sources of advice for smokers and their families. Should it also include the instruction to children that they should never smoke tobacco? Should we imply that those who have had this information and still become smokers will have only themselves to blame if they later develop smoking related illnesses? What effect would we expect if we did?

How do children learn? A philosophical approach

Philosophers have wrestled with this question throughout human history. Aristotle believed learning occurred through the repetition of simple exercises, while Socrates held the view that when a child was conceived he or she contained all the knowledge and skills needed for adult life, but these were 'lost' during birth. Importantly, Socrates also believed that this knowledge could be reacquired through the processes of questioning and enquiry. In the seventeenth century John Locke introduced the idea that the newborn mind is a blank slate (or *tabula rasa*) on which experience and repetition can be written. In his view learning should be enjoyable, but inevitably some learning is also painful – as we find out when we step on a sharp object!

Locke was a major influence on the thinking of another philosopher of the eighteenth century: Jean-Jacques Rousseau. Rousseau believed that all children are born 'good' and argued for developmentally appropriate

education which was experiential. He reasoned that children learned best when they could experience the physical, social and moral consequences of their behaviour and that the tutor or teacher should construct an environment where that learning could occur safely.

Like Rousseau, the US philosopher John Dewey was also a liberal reformer. Writing at the end of the nineteenth and beginning of the twentieth century, Dewey was concerned with social reform through democracy and the active participation of citizens in shaping their own destiny. He was influenced by other liberal educators including Froebel and Montessori and developed pedagogy with the child at the centre who takes an active role in shaping and participating in the curriculum. Dewey's view of education reads much like the definition of PSHE education adopted by the PSHE Association:

> to prepare him for the future life means to give him command of himself; it means so to train him that he will have the full and ready use of all his capacities. (Dewey, 1897: 6)

Another social reformer working around the same time and who had practical experience of teaching (albeit mainly adults) was John Ruskin. He favoured personalised learning which was appropriate for the individual needs of the learner.

> One man is made of agate, another of oak; one of slate, another of clay. The education of the first is polishing; of the second, seasoning; of the third, rending; of the fourth, moulding. It is of no use to season the agate; it is vain to try to polish the slate; but both are fitted, by the qualities they possess, for services in which they may be honoured. (Ruskin, 1853)

The thinking of these liberal philosophers and reformers continues to influence the way we approach teaching and learning in the twenty-first century, supported increasingly by more empirical studies of child development, experimental studies in teaching and learning and, of course, our growing understanding of the developing brain.

Theories of learning

Early theories of learning were based on studies of the behaviour of laboratory animals. Pavlov famously noticed that dogs began to salivate when the technicians who fed them entered the room. He experimented

with other, more neutral stimuli, such as the sound of a bell, which became associated with the reward of food. The theory of classical, or Pavlovian, conditioning was modified and extended by Skinner to operant conditioning which more closely simulated the real world. In operant conditioning a spontaneous but useful response could be both encouraged (with a positive reinforcement) and discouraged (with a negative reinforcement or punishment). The crucial difference is that in classical conditioning it is what happens before the observed behaviour which determines whether the behaviour is repeated, whereas in operant conditioning, it is what happens after the behaviour which is relevant.

Other psychologists showed that both classical conditioning and operant conditioning can be effective in modifying some behaviours in children, and the behaviourists' approach, as it became known, is still in use in education today. For example, operant conditioning is the basis of the use of reward and punishment systems in schools. The behaviourists' view of learning also concurred with Aristotelian views of education that learning was based on repetition and association and encouraged rote learning, for example of times tables and poetry.

Consider

How would a behaviourist approach teaching and learning in PSHE education? Is there a place for rote learning in the twenty-first-century curriculum? What are the advantages and disadvantages of this approach?

What do we need to know about cognition to teach PSHE education effectively?

The early behavioural psychologists paved the way for 'cognitive' psychologists who tried to understand the mental processes behind learning. When a dog learned to associate a sound stimulus with food and respond with a specific behaviour, or a cat learned how to get out of a box, what was the link between 'knowing' and 'doing'? In the 1930s, Tolman, a student of Skinner, showed that experience could lead to learning which, although not immediately expressed as observable behaviour, when rewarded, would lead to a rapid behavioural response. Rats placed in a maze soon learned how to find the food box if it contained food. Their 'cognitive' map of the maze worked just as well if the rats had to walk or

swim through the maze, so the behaviour was not specific to their internal map of the maze. Rats placed in the same maze with no reward did not learn to go directly to the food box but continued to wander around apparently aimlessly. However, if the same rats were then rewarded with food they learned where to find it more quickly than the first group, suggesting their apparently aimless wandering had provided them with a mental map of the maze they could then draw upon when needed.

These forms of learning, known as S-R or stimulus–response learning can be compared with another form of learning known as insight learning. These ideas are based on studies of chimpanzees by Kohler, a cognitive scientist. Kohler observed that chimpanzees used sticks placed outside their cages to stretch to bananas which were out of reach. The connection between the stick and the banana did not occur as a result of a random series of events, but after period of failure, followed by 'reflection'. However, some would argue that insight learning is an extension of S-R learning because both sticks and bananas were already part of the chimpanzee's experience. Other experiments with chimpanzees by Harlow and others showed how by repetition of a familiar task using different stimuli, a chimpanzee could learn how to learn. In other words the chimp had developed a set of rules to solve a new but familiar puzzle – a bit like doing a new Sudoku or crossword.

Consider

Children are taught how to cross the road safely in streets close to their school. The rules of 'stop at the kerb, look all around, listen and walk straight across the road' are learned and applied to all similar roads, whether near the school, near their home or when out and about with friends and family, so that they can soon do so in all weathers and in all lighting conditions. The more experience they gain the more they can adapt the rules they have learned to their situation, for example the necessity in some circumstances to cross between parked cars – which they are often expressly taught not to do, but which can be unavoidable in some urban environments.

Increasingly cognitive scientists have used sophisticated experiments with human subjects to discover how children develop mental or cognitive maps of mathematical concepts and reading.

What do we need to know about child development to teach PSHE effectively?

Unlike the behaviourists, and early cognitive psychologists, the developmental psychologists Piaget, Vygotsky and Bruner based their theories directly on their studies of children. Piaget carried out intensive observations of his own children, proposing his famous 'stage theory' of a child's cognitive development, where thinking develops from concrete to abstract forms in fixed, linear and irreversible stages. Other 'stage theories' flourished including Kohlberg's theory of moral reasoning. Piaget also proposed that children's understanding is actively constructed by assimilating new information into existing 'schema', accommodating or modifying the schema until the new information fits. Although criticised for being based on small samples of children from a particular culture, and on a deficit model of a child – that is, what a child cannot do, rather than what they can – Piaget's theories continue to influence teaching and learning, especially in the early years where play and discovery learning go hand in hand.

Importantly for PSHE education, Piaget and other constructivists suggest that children's reality is different, although not inferior, to an adult's reality and that to understand a child's point of view you must first understand their reality. Another key figure among the constructivists is Jerome Bruner, an American psychologist who also believed that children build new understanding on what they have already mastered, through enquiry and intuition. Rather than a stage-based approach he suggested that children, and adults, learn in broadly similar ways using three forms of representation: 'action' based, 'image' based and 'language' based. In Bruner's view a learner of any age can understand most concepts if the material is organised appropriately, with more and more specific activity, images and language to 'scaffold' the learning as they progress. Bruner's ideas have led to the notion of a spiral curriculum where teaching is planned so that the learner can build on their prior knowledge and understanding more easily.

☁ Consider

The spiral curriculum has been very influential in all areas of the curriculum. Where did you first hear this term? How have you used the idea in your planning, for example in mathematics or science education? How could you use this in PSHE education?

It can also be seen that a constructivist approach has much in common with the ideas of Rousseau, Froebel and Montessori who believed learning should follow a child's natural development. To return to the question at the beginning of this chapter – according to a constructivist approach,

> learning is the search for meaning. (Muijs and Reynolds, 2011: 88)

Taken together these ideas suggest that PSHE education should be based on active and discovery learning, with the teacher in the role of 'facilitator', and not just in the early years.

Bruner also shared views similar to other twentieth-century developmental psychologists such as the Russian, Vygotsky, in stressing the importance of culture and social interaction in learning. Like Piaget and the other constructivists, Vygotsky adopted a child-centred approach to learning and believed that children actively construct their reality based on existing understanding. Vygotsky did not fully support the idea of a staged approach to development, arguing that tasks which are too challenging could lead learners to regress to 'earlier' forms of learning.

In PSHE education Vygotsky's idea of the 'zone of proximal development' has become influential. Contrary to Piaget's view, that learning happens at fixed stages in a child's development and cannot, therefore, be accelerated, Vygotsky proposed that it is possible to help a child to learn more quickly if you can assess their starting point, which includes their capacity to learn. A teacher can then plan to provide appropriate activity and support so that the child can progress to the next level of understanding. However, a Vygotskyan teacher would support the learning by encouraging collaboration with more knowledgeable peers rather than give instruction.

For social constructivists like Vygotsky the social context in which learning takes place is more important than the learning material, and this idea is also important for PSHE education. Teachers, family members, peers, the wider community and the media all contribute to the learner's development though formal and informal learning.

💭 **Consider**

How might a social constructivist's approach to drug education differ from that of a behaviourist? What kind of strategies for teaching and learning would they adopt?

Other social psychologists including Bandura and, later, Bronfenbrenner have also stressed the importance of environmental factors in children's learning. Bandura showed through observation and experiment that children imitate behaviour they observe in others, particularly if they identify with the people whose behaviour they are modelling. Bandura's theories are commonly used to explain socially unacceptable behaviour such as aggression or attention seeking in young children. Bandura also proposed that as a result of early social experiences children develop strong beliefs about their abilities to do well and achieve success in particular situations. Known as self-efficacy, this factor can have a strong influence on children's motivation to tackle challenging tasks, since they 'know' in advance whether or not they will succeed, either of which can become a self-fulfilling prophecy. For PSHE education, this means that it is of great importance to model and reward efforts to practise the behaviours we are encouraging through our approach to teaching and learning.

Bronfenbrenner's ideas have been very influential in the development of approaches to combating disadvantage among very young children. His ecological theories of child development were fundamental to the introduction of the Headstart programme of early years education in the USA, which in turn influenced the Sure Start programme in the UK.

While Bandura's work is mainly focused on the individual child, Bronfenbrenner emphasises the ever changing context in which development takes place: family, school and the wider society in which the child lives, as well as the events and transitions taking place as they mature. For PSHE education, Bandura, Bronfenbrenner and other social psychologists offer a way to understand how to support the development of resilience in children and young people, through the development of individual skills and attributes and by creating environments in which they can learn to manage change successfully.

> ### Consider
>
> Is PSHE education concerned with developing the capacity of children and young people to manage their lives effectively, or a vehicle for social reform?

What does all this mean for PSHE education?

Many of the approaches to teaching and learning in PSHE education are based on a blend of behaviourist, constructivist and social constructivist approaches, which:

- start where children are, with their knowledge, understanding and experiences
- scaffold the learning with developmentally appropriate but increasingly complex activity, imagery and language as part of a spiral curriculum
- encourage reflection to promote the assimilation of learning
- use collaborative approaches (small group work)
- employ positive language, reinforcement, modelling and rewarding the behaviours you wish to encourage
- recognise the influence of family and wider society.

In the rest of this chapter we will continue to develop these ideas, drawing on evidence and theory from other disciplines which have also helped to inform our understanding of effective practice. At the end of this chapter these ideas are summarised in the form of ten principles for effective practice in PSHE education.

What do we need to know about learning styles to teach PSHE education effectively?

The idea that different people learn best in different ways began to assert itself in the 1970s and 1980s with the work of David Kolb. Kolb was concerned mainly with organisational psychology and therefore with how adults learn. He saw experiential learning as a holistic, integrative approach which incorporated the understanding of many of his predecessors, who tended to argue for one or other model of learning (Kolb, 1984). Kolb argued that learning takes place through concrete experience, reflective observation (watching others), abstract conceptualisation (creating theories that explain observations) and active experimentation (problem solving and decision making). In Kolb's view these were stages through which all learners move with time. Some psychologists suggest that learners gradually rely on, and so develop a preference for, particular learning styles (see Muijs and Reynolds, 2011) and others suggest that particular professions attract those with certain learning styles, implying that knowing someone's learning style can determine their suitability for those professions.

Other typologies of learning styles are based on the different senses employed for learning, for example Visual, Auditory, Kinaesthetic learning or VAK (Dunn and Dunn, 1978).

Proponents of these theories have developed approaches to teaching which reflect the various typologies of learning. For example a teacher might choose a range of teaching strategies to ensure that children in the class can all access the learning equally, whatever their learning style.

There is something appealing and intuitive about these theories, which make sense at one level. Some children, and adults, do seem to learn by rote better if they can also be physically active at the same time; some children recall information for exams better if they can listen to instrumental music they heard while learning (Angel et al., 2010).

Critics of these approaches argue that people use different approaches to learning for different subject areas. For example auditory learning might be very important for the acquisition of a foreign language while tactile or kinaesthetic learning might be more important for acquiring practical skills such as crossing the road or making bread. More importantly, there appears to be no empirical evidence that preferred learning styles can be measured in any reliable way (Pashler et al., 2008).

Perhaps an understanding that there can be different learning styles should remind teachers to offer a variety of approaches in the classroom, which in turn will prevent children from becoming bored by the teacher's preferred teaching style!

What do we need to know about intelligence to teach PSHE education effectively?

It is all too apparent that health and wellbeing are not determined by 'intelligence'. Clever people, those who achieve national and international recognition for their achievements in science, mathematics, engineering or the arts, have problems with money, substance misuse and relationships and become ill just like the rest of us. Traditionally intelligence has been measured by the Intelligence Quotient (IQ) (see Gross, 2010, for an overview). IQ tests measure a range of intellectual capacities from spatial and numerical reasoning to memory and verbal reasoning. Some people perform better in some of these 'primary mental abilities' than others, but many psychologists argue that there is an underlying factor which correlates positively with the individual tests, known as 'g'. Attempts to define and measure IQ are of great social and political importance. If a test can predict which 11-year-olds will become the doctors, engineers, plumbers and shop assistants of the future, then their education could be tailored to suit their different abilities. (More examples of self-fulfilling prophecies, perhaps?) Critics of such tests argue that their predictive value, especially when carried out at the age of 11 years, is not high enough to differentiate children on the basis of this alone. IQ tests have also been criticised for being biased in terms of race, gender, social class and culture (Gould, 1996).

This controversy has contributed to an ongoing search for measures which describe intelligence in different ways, which capture more about

the forms of intelligence used in the world outside school, such as the 'ability to deal with relative novelty'. One of the most well-known theories of intelligence was developed by Howard Gardner in the 1980s (Gardner, 1983). In his view intelligence is a collection of independent but interacting intelligences. According to Gardner each intelligence can be measured using standardised psychometric tests; resides in a specific region of the brain, which is identifiable by studying patients with brain damage; and can be observed in extreme forms by 'idiots savants', who despite severe disability can achieve remarkable feats.

Gardner's intelligences include: linguistic, logical mathematical, spatial, musical, bodily kinaesthetic and – importantly for PSHE education – *inter*personal and *intra*personal intelligence.

Around the same time the idea of emotional intelligence was also developing. This could be seen as separate from but complementary to 'conventional' intelligence. Goleman observed that in business, leaders with similar intellectual ability could be differentiated on the basis of their Emotional Quotient or EQ (Goleman, 1995) and it has been suggested that those with a high EQ perform better than those with a low EQ (Weare, 2004). It is important to note that the ideas underpinning EQ have come from observations with adults rather than children, whose brains continue to develop throughout their school years and beyond.

The work on multiple intelligences, and specifically emotional intelligence, has led to the development of a range of resources for schools which focus on social and emotional development as a way of improving a wide range of outcomes, for example Social and Emotional Aspects of Learning for Primary Schools (SEAL) which was implemented in schools across England with support from the Department for Children, Schools and Families, now the Department for Education (DfE). A small scale independent evaluation of SEAL suggested some positive findings for children with regard to a range of beneficial social outcomes which were sustained over several weeks (Humphrey et al., 2008). SEAL resources have been archived by the DfE but are still accessible through the Teachfind website (see p. 88).

We will look again at EQ when we review social and emotional well-being in Chapter 3.

What do we need to know about brain development to teach PSHE education effectively?

This section has drawn on a collection of essays arising from a seminar 'Mind, Brain and Education' held in 2003 (Battro et al., 2008). Compared

with the philosophical or psychological approaches to understanding children's learning, described above, our understanding of brain development is in its infancy. Until relatively recently much of what we understood about the brain and learning was based either on animal studies where parts of the brain were deliberately damaged, or on observing the effects of brain injury on human behaviour. Some studies were also carried out during brain surgery, when the patient was not anaesthetised. (The brain itself has no pain sensors!)

However, great strides have been made in the last 30 years, assisted by non-invasive techniques for studying the brains of living people such as: functional magnetic resonance imaging (fMRI), magneto-encephalography (MEG) and optical topography (OT) (Koizumi, 2008). Each technique has its strengths and weaknesses and the results are often combined. While fMRI and MEG require the individual to be motionless, OT enables neuroscientists to study the brains of infants and children while they are going about their normal activities, and has recently been used to demonstrate that adults with 'locked in syndrome' are conscious.

For educationalists the important questions are not about how the brain develops but, rather, how this knowledge can help us to make sense of theories of cognition, child development, learning styles and multiple intelligences, or help us to relate to the work of the philosophers whose work we continue to respect despite the passage of time.

Many people believe we can begin to make these links and this has spawned a plethora of novel resources for schools, which could loosely be described as brain based learning. However, some of the leading researchers in the field have urged caution in leaping to conclusions about curriculum development, based on our, as yet imperfect, understanding of the relationships between brain development and learning (Fischer, 2008).

There is still a lot to learn about the link, for example, between cognition (understanding), the specific area of the brain which is activated when learning or performing a specific task, and whether a child demonstrates that learning reliably in the future in an unfamiliar setting. Some evidence points clearly to the work of the behaviourists: groups of neurones become associated with one another through synaptic connections which are reinforced through repetition. According to Singer: 'Neurons wire together if they fire together' (Singer, 2008: 100).

As the brain matures these processes become irreversible. This is why early experience is so important to 'normal' development. This observation also leads some neuroscientists to suggest that there are critical periods in brain development when the neuronal structure is optimised to develop a specific function. The development of language is a good

example of this. Numerous studies have shown that babies make all the sounds heard in all human languages but that gradually they selectively pay attention to and mimic the speech sounds in their immediate environment, especially maternal speech. They acquire a vocabulary and use recognisable grammatical rules to make new sentences they have never heard spoken before. Gradually the ability to learn new languages becomes more and more difficult (although some people appear to learn how to learn and become fluent in many languages).

Interestingly, neuroscientists make a clear distinction between learning and education, using knowledge of how the brain works to explain not just how we learn about maths or reading, but also human attributes such as love and hate: 'Learning is the process of making neuronal connections in response to external environmental stimuli, while education is the process of controlling or adding stimuli and of inspiring the will to learn' (Koizumi, 2008: 167).

It is clear there is much more to learn about the role the brain plays in education.

> ### ☁ Consider
>
> We often hear the term 'teaching and learning' used in curriculum planning. What does brain science tell us about teaching and its relationship to what is learned?

What do we need to know about childhood to teach PSHE education effectively?

After all this discussion of child development, learning theory and brain development, it is important to reflect that we should not think about children as brains, or even as learners, isolated from the rest of their lives in the community. We must remember that while children are at school they are also in a very important phase of their overall development: a phase which we know as childhood.

The limits of childhood are not determined by biological factors (according to some, brain development continues up to the age of 30, which is beyond even the broadest definition of childhood!). The definition of childhood varies from culture to culture and across time. Hence childhood is described as a social construct, dependent for its meaning on the interactions of a particular group of people, rather than an objective or inherent reality. Indeed, childhood is a relatively new construct, arising in the seventeenth century with the industrial revolution and the

emerging awareness of adults of the need to protect children from the effects of heavy work and the harsh conditions in the factories.

PSHE education in primary schools is taught to children between the ages of 4 and 11 years (or 12 years in Scotland). This means that however childhood is defined, children of primary school age are included and so are affected by what we understand by this term.

> ### Consider
>
> What does childhood mean to you? How is it shaped by the culture in which you have grown up? Is it a time of innocence, freedom and play? Or a time of forced labour, prostitution and military service? Or a time of economic dependence or economic exploitation?

By the late twentieth century sociologists began to question notions of childhood and whether the study of childhood in some ways disempowered children as actors or 'agents' in their own lives (Moran-Ellis, 2010). The idea of childhood, with its early focus on protecting children, had become, for some, a means of objectifying and demeaning children. This can be seen to some extent in the research into child development described earlier in this chapter. Psychological research tended to be done 'on' children as subjects, rather than 'with' children, as participants, as if they had no insights of their own to bring to the discussion, even when the aim of the research was to understand children's needs.

A 'new sociology of childhood' emerged which had parallels with the social constructivist movement in psychology. Indeed, the work of Vygotsky and Bronfenbrenner, among others, was influential in shaping this new approach, placing children at the centre of studies of childhood, through methodology more familiar in anthropology, ethnography, history and geography than from psychology or sociology. Allison James and Alan Prout, leading sociologists in this field, argued that we should see children as agents in the here and now and not as future adults (James and Prout, 1990).

> ### Consider
>
> In PSHE education, learning is the process through which 'children and young people acquire the knowledge, understanding and skills they need to manage their lives, now and in the future'. How does this definition reflect the new sociology of childhood?

The view of childhood in the UK in the early twenty-first century can be described as confused. According to Moran-Ellis (2010: 189), politically, children are seen simultaneously as 'in danger' (and so must be protected) and 'a danger' (and so we must be protected from them). This has led to social policies and practices which have contributed to children in the UK being ranked lowest overall for 'wellbeing' of 21 developed countries (UNICEF, 2007). A closer look at these rankings shows that while the UK is placed twelfth for health and safety, it is placed twenty-first for family and peer relationships, suggesting our motivation and efforts to keep children physically safe do not match those which would keep children emotionally safe.

What do we need to know about risk and protective factors to teach PSHE education effectively?

It is well known that some children are more likely than others to have problems now and in the future. The features of their lives which make them more vulnerable are known as risk factors. Similarly, some children appear to be relatively untouched by the same risk factors and appear to benefit from protective factors, which, interestingly, are not always the reverse of risk factors (Jessor et al., 1995, 1998).

It is important to remember that risk and protective factors do not *predict* outcomes for children and young people but are factors which are correlated with more or less positive outcomes. Some children grow up in very adverse circumstances and lead happy, healthy and successful lives. Others appear to have many advantages and yet experience serious problems. Also risk factors are not static; they can change according to the broader social and economic situation in which the child is growing up. This suggests that education may be able to influence the outcomes for vulnerable young people, although not only in conventional ways, through knowledge acquisition (Cleveland et al., 2008).

Risk and protective factors can be divided into several domains (Cleveland et al., 2008):

- individual (for example, knowledge or skill)
- school (for example, policy, connectedness to school)
- peer group (for example, attitudes and social norms)
- family (for example stability, parental rules)
- community (for example, crime rates, neighbourhood attachment).

Risk factors also vary according to the problem, so risk factors for bullying are different from those for child abuse, although there are some

which are common to both. Some problems can themselves become risk factors and can lead to a child becoming vulnerable to other problems. For example, young people who have serious problems with substances such as alcohol may report that they were bullied when they were younger, or suffered abuse or neglect at the hands of adults.

Similarly protective factors are not static and can vary from one problem or issue to another. However, protective factors which promote resilience – such as stable, supportive relationships with significant adults, achievement which is recognised and valued by school or the community, and engagement in a range of activities – are often cited as protective for a range of potential problems such as drug misuse and bullying. According to Cleveland et al. (2008) different protective factors can be important for children of different ages, with family and community factors being of greater value to younger children, and peers and school having greater impact for adolescents.

How can an understanding of health-related behaviour help us to teach PSHE education effectively?

Much of what we understand to be effective practice in PSHE education is rooted in an understanding of health, health promotion, health-related behaviour and public health, which aim to improve the health and well-being of individuals and communities (for an introduction to health promotion see Naidoo and Wills, 2009).

The health and longevity of the population of the western democracies has improved considerably since the end of the nineteenth century. Economic development and public health measures aimed at the whole population, such as better housing and working conditions, cheaper food, improved sanitation, vaccination and other advances in medicine, have all played their part. Improving health has led to longer, more economically active lifestyles for a large majority of the population, but not for everyone, with the poorest still experiencing the worst health (Doran et al., 2004). Genetic differences also influence our health and wellbeing. Finally, we have to consider too the influences on individual health-related behaviour for those who have real choices about diet and exercise.

PSHE education often focuses on the issue of individual behaviour, but as you will see in Chapter 3, how the whole school addresses the needs of the children and its community is also a powerful influence. Just as biology is fundamental to much of our understanding in public health and medicine, the social sciences too such as psychology, anthropology, economics and sociology have also increased our understanding of health and health-related behaviour.

Human behaviour is complex and changes throughout the life course. There are several models and theories which can help to describe our health-related behaviour. The models and theories also help to predict what will happen if we try to influence the way individuals behave. In this section we describe some of the better-known models and their implications for PSHE education.

Remember, in PSHE education we are trying to create the circumstances where the healthy and safe choice is the easy choice, and to enable young people to act on those choices. We are not trying to predetermine their behaviour or the choices they should make.

The Health Belief Model

This is one of the oldest and simplest models of health-related behaviour. Its basic premise is that we need a stimulus to change unhealthy behaviour
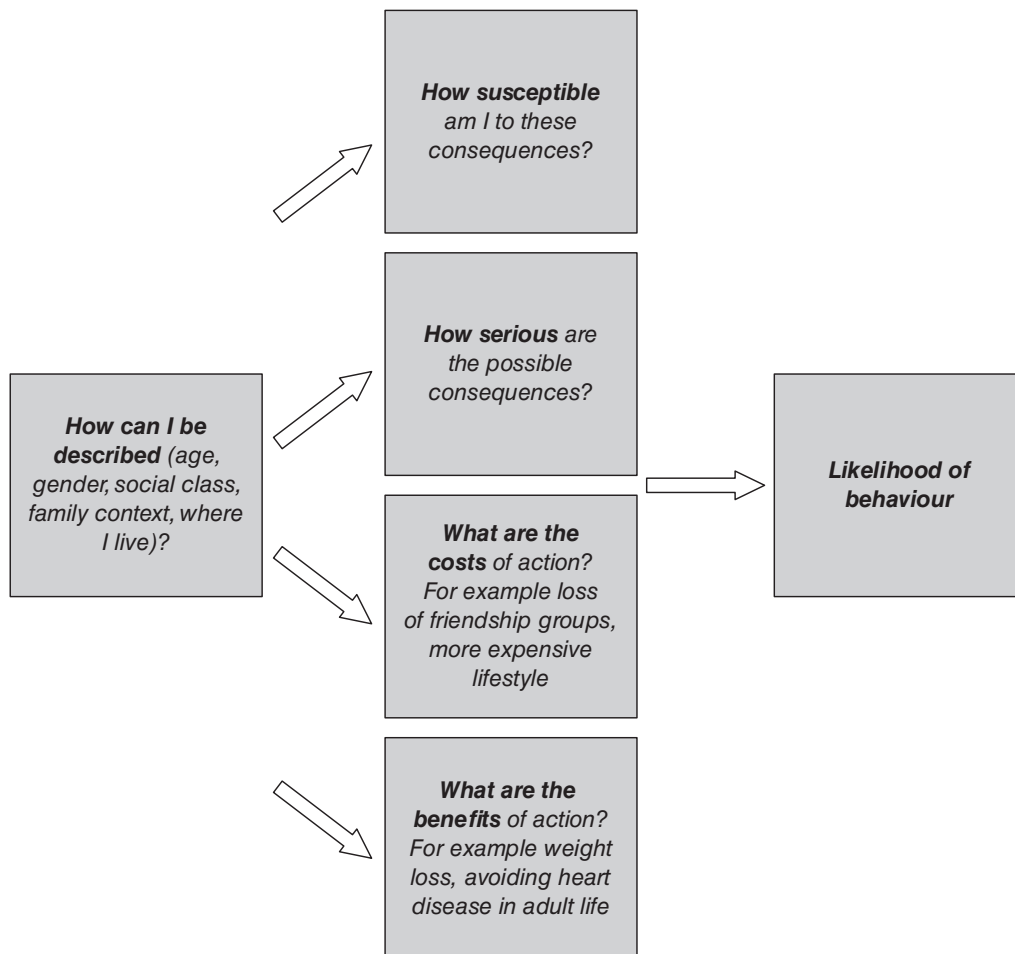

Figure 2.1 Health Belief Model (based on Becker, 1984)

to healthy behaviour. The model assumes that each person knows and understands the benefits of changing their behaviour (for example giving up smoking) and then makes a rational decision based on the costs and benefits of the change.

Key to the model is that an individual:

- is motivated to change
- believes their present behaviour represents a threat to their health
- believes the benefits outweigh any costs
- feels competent to carry out their decision.

Various other factors are known to influence or modify how people respond. These include:

- demographic factors such as age, gender and ethnicity
- psycho-social factors such as personality, social class, peer and other social norms
- structural factors such as knowledge of the possible outcomes, availability of advice and services, prior experience or experience of close family members or friends.

It is important to note that the Health Belief Model is a model to explain health-related behaviour, not a behaviour change model. Nevertheless, the Health Belief Model is the basis of many past educational campaigns and approaches. This is because it seems to suggest that providing knowledge about, or creating fear of, a disease or illness can help groups of people to avoid poor health outcomes. However, in practice, we know that knowledge is necessary but not sufficient to change individual behaviour, so educational approaches based only on information are unlikely to result in better health outcomes.

Fear arousal, which might increase our perceived susceptibility to disease, is also not very effective in changing behaviour, especially among young people. One reason for this is that young people have less experience to call on when comparing the information they are given with their own behaviour. They may not have experienced ill health themselves or in their immediate family. Young people also tend to demonstrate 'optimistic bias', because they may not immediately understand how the information applies to them. For example, young people often overestimate what they might earn in the future, and underestimate what basic services and goods cost. Non-smokers may think they are not likely to have heart disease, even though they are overweight and take no exercise. This phenomenon gives the false impression that young people think they are invulnerable – and this in turn can lead adults to exaggerate the magnitude of the problem, or to

use scare tactics to emphasise the risks. We return to this in Chapter 11 (drug education).

A similar problem arises with a moralistic approach to health issues. Children find it difficult to see how someone they know to be 'good', such as a parent, can also do something 'bad', such as provide unhealthy food or drive without a seatbelt. So approaches to PSHE education which attempt to make people feel guilty are also likely to fail.

Another criticism of the Health Belief Model is its relative simplicity. Health-related decision making is much more complex than a series of rational calculations based on factors over which you may have no immediate control.

Where the Health Belief Model has been most successful is as a part of 'motivational interviewing'. This approach encourages individuals, rather than groups, to recognise the risks to their health, but focuses on the benefits of changing behaviour and helps people to consider what would help them to change. There is an emphasis on empowering people to make small, manageable changes which can be built upon as confidence grows. Brief motivational interviews with vulnerable young people who are beginning to have problems with drugs have been shown to be very effective, when carried out by trained workers (NICE, 2007).

Theory of Planned Behaviour

As its name implies, this theory suggests that health choices are planned and carried out on a rational basis. However, this theory also recognises that our beliefs affect our intentions and these intentions can to some extent predict whether or not we will turn our intentions into action. While a moment's reflection confirms that we do not always behave as we intend, the Theory of Planned Behaviour suggests that the strength and stability of the beliefs underpinning our intention are crucial. This means that beliefs which have been held and reinforced over a long period, which are held by other people in the same social group, and which coincide with other related beliefs are more likely to influence our behaviour, positively or negatively. As this is a theory of behaviour change it has little to say about the maintenance of existing healthy behaviour which applies to children of primary school age, the overwhelming majority of whom have not yet
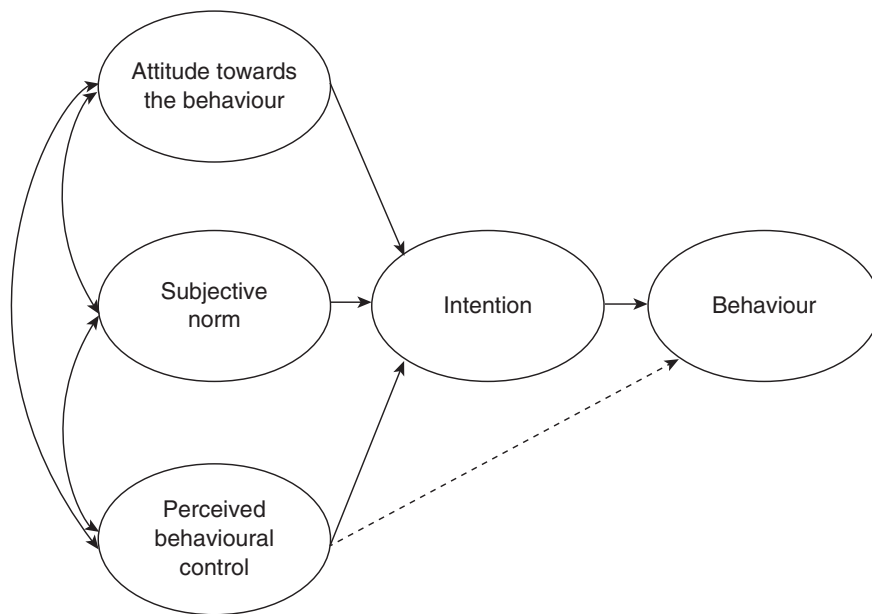
Figure 2.2   Theory of Planned Behaviour

Source: Ajzen, 1991: 182

started to adopt risky behaviours such as smoking, drinking alcohol or using illegal drugs.

One of the most important things we can learn from the Theory of Planned Behaviour is the importance of social norms in influencing our intentions. Social norms are what we believe to be acceptable values, beliefs and behaviours. They are the often unwritten, sometimes even unspoken, rules by which we conduct our everyday lives. Social norms vary from culture to culture, but also from generation to generation within a social group. Some social norms are communicated explicitly through the law, or by a formal religious custom, but some forms of communication are more subtle, such as how we dress, what words we use and what topics of conversation are acceptable.

Adolescents seem to be particularly alert to the social norms among their age group and may feel compelled to conform, as they may believe that not conforming will result in them being shut out or ostracised by their peers. However, some reviewers suggest that so-called 'peer pressure' is a far less powerful factor in risky behaviour among young people than has been thought (Coggans and Watson, 1995) and may be more appropriately described as 'peer influence'.

It is important to realise that social norms are often informal and some are more accurately described as perceived social norms. For example, young people may believe that most people in their age group regularly use illegal drugs. However, this norm may be influenced by a few prominent members of their peer group, by the media – and by the exaggerated fears generated in PSHE education lessons! Carefully constructed and properly administered anonymous surveys demonstrate that most young people of school age in the UK do not use illegal drugs – and that the proportion who do is falling. According to Gill et al. (2012) cannabis use among young people aged 11–15 years in England has almost halved from 13.4 per cent in 2001 to 7.6 per cent in 2011. As far as substance misuse is concerned, it seems that the actual norm is very different from the perceived norm.

The Theory of Planned Behaviour tells us that making sure children and young people know how few of their peers use illegal drugs will strengthen the beliefs underpinning a young person's intention not to use drugs themselves. It also suggests that PSHE teachers should challenge perceived norms where they may have a damaging influence.

Primary school-age children might have a very exaggerated and misplaced belief about secondary school pupils' use of drugs, for example, which may need to be addressed. Young people who believe, erroneously, that most of their peers use illegal drugs would therefore also observe that most do not suffer any ill health consequences. As a result they may dismiss any information about the potential harm caused by illegal drugs as exaggeration, whereas they have simply overestimated drug use among their peers. Thus it is the responsibility of PSHE education to provide information that is not only relevant but also objective, accurate and balanced. Challenging perceived norms by encouraging discussion and reflection of the facts about young people's drug use is a normative approach to drug education and this has been shown to be effective in several studies (Stead and Angus, 2004).

If we reflect on the Theory of Planned Behaviour, challenging perceived norms about healthy behaviour can have two benefits. It can reinforce the majority who have made healthy choices and help to change beliefs that may contribute to unhealthy choices.

Health Action Model

The Health Action Model (Green and Tones, 2010; Tones, 1987) focuses on the interaction between an individual's beliefs, their environment and the contribution education can make to their intentions to act in a given
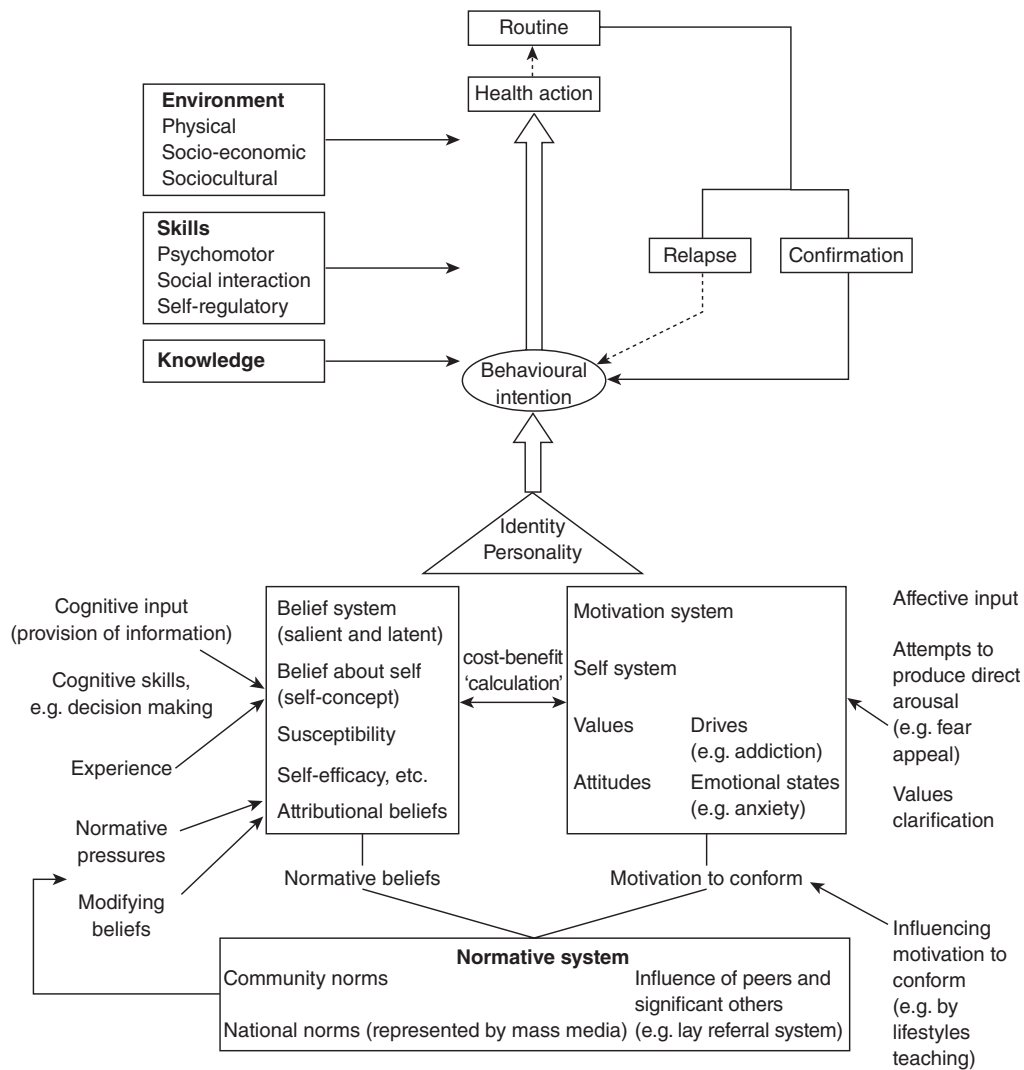
Figure 2.3   Health Action Model

(adapted from Tones, 1987, and Green and Tones, 2010)

way. It draws on well-known models including the Health Belief Model and the Theory of Planned Behaviour, among others (see Green and Tones, 2010).

Although this model is not as well known as the others it is included here because the Health Action Model is particularly useful for planning in PSHE education. Various versions have been published over a

period of 20 years with Figure 2.3 based on two – one older and one more recent. At the base of this model are the norms of our community, family and peers, which have a powerful effect on our motivation and beliefs about health behaviour. The lower right-hand side shows how emotional arousal can influence our intentions. This typically occurs via high profile roadshows and media campaigns intended to make us fearful of the consequences of unhealthy behaviours, while in PSHE education it may be through Theatre in Education, as well as in lessons, which enable young people to reflect on and clarify their values with respect to health behaviour. This 'affective input' is balanced by the lower left-hand side of the model which suggests that efforts to help young people to feel good about themselves (self-worth) and to feel capable and confident in carrying out their decisions (self-efficacy) will also help them to form healthy intentions. Fear arousal without this balancing is unlikely to be effective in changing behaviour (Ruiter et al., 2001).

The upper left-hand side of the Health Action Model suggests that the policies of a school should be congruent with the health behaviour we are asking young people to demonstrate. Within this setting children and young people should have structured opportunities to practise the social, emotional and physical skills they need to recognise their feelings, make choices and decisions and be able to take risks in a safe and supportive environment. This could be through role play, team building and physical challenges which test their competence and may not just be in PSHE education but also in opportunities for adventurous and challenging activities. Classroom activities can never be exactly like the real world, but should always provide an opportunity for young people to reflect on their actual experience. Schools can also provide real opportunities for young people to make and sustain responsible choices in a range of practical ways, and in doing so demonstrate they can help to influence the health, social and economic wellbeing of themselves and others through their choices.

Whole school approaches to health and wellbeing provide the best evidence for the effectiveness of this part of the model. There is growing evidence that 'healthy' or 'health promoting' schools contribute to the development of confident individuals who are competent in their decision making and are resilient in the face of adversity (Stewart et al., 2004; Stewart-Brown, 2006). Interestingly there is also emerging evidence that healthy schools can provide the context for improved

academic outcomes (Murray et al., 2007; Symons et al., 1997) (see also Chapter 3).

The upper right-hand side of the model acknowledges that even when we try to behave in healthy ways we don't always succeed, but that what we learn from failure *and* success can help us to do better next time. This draws on the trans-theoretical model of change developed by Prochaska and DiClemente (1983, 1984) as part of their work in understanding adult addictive behaviour.

Overall, what the Health Action Model really shows us is that in PSHE education there is no magic bullet. It shows that knowledge, social norms, some idea of personal susceptibility, our experience, our environment, our skills in decision making, our confidence in carrying out our decisions and our resilience in the face of setbacks all matter when it comes to whether or not we form healthy intentions and can act on those intentions. This suggests that using a range of approaches to teaching and learning in PSHE education, combined, will be more effective than focusing on one or another as some of the other models suggest.

Chapter summary

In this chapter we have attempted to bring together philosophy, psychology, neuroscience and sociology to inform our understanding of children, learning, teaching and how this can impact on health-related behaviour. All of this material (and more!) can be explored in more depth in more specific texts we have recommended.

Some of what we have covered will be very familiar and some new and, potentially, challenging. Whatever your starting point there is a lot of information to consider every time you plan a PSHE education lesson. To help with this, in 2009, the PSHE Association reviewed similar information and distilled it down to ten principles for effective PSHE education. It is worth noting that the ten principles apply to whole school planning for PSHE education, and not to each and every lesson. The aim is to achieve a balanced approach through formal and informal education, with the guidance of your PSHE co-ordinator, the help of external contributors and opportunities for learning outside the classroom.

Ten principles for effective PSHE education

1. Start where children and young people are: find out what they already know and understand, are able to do and are able to say. For maximum impact involve them in the planning of your PSHE education programme.
2. Plan a 'spiral programme' which introduces new and more challenging learning, while building on what has gone before, which reflects and meets the personal developmental needs of the children and young people.
3. Recognise that the PSHE programme is just one part of what a school can do to help children and young people to develop the knowledge, skills, attitudes and understanding they need to fulfil their potential. Link the PSHE programme to other whole school issues such as Healthy Schools, information, advice and guidance and to pastoral support, providing a setting where the healthy and safe choices become the easy ones. Encourage staff, families and the wider community to get involved.
4. Offer a wide variety of teaching and learning styles within PSHE education, emphasising interactive learning and the teacher as facilitator.
5. Encourage young people to reflect on their learning and the progress they have made, and to transfer what they have learned to say and to do from one school subject to another, and from school to their lives in the wider community.
6. Provide opportunities for children and young people to make real decisions about their lives, to take part in activities which simulate adult choices and, where they can, demonstrate their ability to take responsibility for their decisions.
7. Take a positive approach which does not attempt to induce shock or guilt but focuses on what children and young people can do to be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic wellbeing.
8. Provide information which is realistic and relevant and which reinforces positive social norms, such as saving for the future or not using illegal drugs.
9. Provide a safe and supportive learning environment where children and young people can develop the confidence to ask questions, challenge the information they are offered, contribute their own experience, views and opinions, and put what they have learned into practice in their own lives.
10. Embed PSHE education within other efforts to ensure children and young people have positive relationships with adults and feel valued, and those who are most vulnerable are identified and supported.

> ### 💭 Consider
>
> Can you relate each principle to one or more sections of this chapter?
> Is there anything missing from the ten principles that you would
> include? Why?

Further reading

Dowling, M. (2010) *Young Children's Personal and Social Development*. London: Sage.
  Provides a useful overview of personal and social development for early years practitioners.
McWhirter, J. (2009) *Personal, Social, Health and Economic Education: From Theory to Practice*. London: PSHE Association. Available at: www.pshe-association.org.uk/10principles (accessed 28 January 2014).
  A review of evidence relevant to PSHE education similar to that covered in this chapter, from which the 10 principles were derived.
Miller, D. and Moran, T. (2012) *Self-esteem: A Guide for Teachers*. London: Sage.
  This book will help you develop classroom strategies for developing intrapersonal skills which enhance self-esteem.

References

Ajzen, I. (1991) 'The theory of planned behaviour', *Organisational and Human Decision Processes*, 50: 179–211

Angel, L.A., Polzella, D.J. and Elvers, G.C. (2010) 'Background music and cognitive performance', *Perceptual and Motor Skills*, 10 (3C): 1059–64.

Battro, M., Fischer, K.W. and Lena, P.J. (eds) (2008) *The Educated Brain*. Cambridge: Cambridge University Press.

Becker, M.H. (1984) *The Health Belief Model and Personal Health Behaviour*. Thorofare, NJ: Charles B. Slack.

Berk, L.E. (2007) *Infants, Children and Adolescents*. Needham Heights, MA: Allyn and Bacon.

Cancer Research UK (2012) www.cancerresearchuk.org/cancer-info/cancerstats/types/lung/smoking/lung-cancer-and-smoking-statistics#cancer (accessed 14 May 2013).

Cleveland, M.J., Feinberg, M.E., Bontempo, D.E. and Greenberg, M.T. (2008) 'The role of risk and protective factors in substance abuse across adolescence', *Journal of Adolescent Health*, 43 (2): 157–64.

Coggans, N. and Watson, J. (1995) 'Drug education: approaches, effectiveness and delivery', *Drugs: Education, Prevention, and Policy*, 2 (3): 211–24.

Dewey, J. (1897) 'My pedagogic creed', *The School Journal*, 54 (3) (16 January): 77–80.

Doran, T., Drever, F. and Whitehead, M. (2004) 'Is there a north–south divide in social class inequalities in health in Great Britain? Cross-sectional study using data from the 2001 census', *British Medical Journal*, 328: 1043–5.

Dunn, R. and Dunn, K. (1978) *Teaching Students Through Their Individual Learning Styles*. Reston, VA: Reston Publishing.

Fischer, K.W. (2008) 'Dynamic cycles of cognitive and brain development: measuring growth in mind, brain and education', in M. Battro, K.W. Fischer and P.J. Lena (eds), *The Educated Brain*. Cambridge: Cambridge University Press, pp. 127–50.

Gardner, H. (1983) *Frames of Mind: Theory of Multiple Intelligences*. New York: Basic Books.

Gill, V., Hawkins, V., Mandalia, D. and Whalley, H. (2012) *Smoking, Drinking and Drug Use Among Young People in England in 2011*, ed. E. Fuller. London: Health and Social Care Information Centre.

Goleman, D. (1995) *Emotional Intelligence*: *Why It Can Matter More Than IQ*. New York: Bantam Books.

Gould, J. (1996) *The Mismeasure of Man*. New York: W.W. Norton & Company.

Gray, C. and MacBlain, S. (2012) *Learning Theories in Childhood*. London: Sage.

Green, J. and Tones, B.K (2010) *Health Promotion: Planning and Strategies*. London: Sage.

Gross, R. (1996) *Psychology: The Science of Mind and Behaviour*. London: Hodder and Stoughton.

Gross, R. (2010) *Psychology: The Science of Mind and Behaviour*. London: Hodder and Stoughton.

Humphrey, N., Kalambouka, A., Bolton, J., Lendrum, A., Wigesworth, M., Lennie, C. and Farrell, P. (2008) *Primary, Social and Emotional Aspects of Learning (SEAL): Evaluation of Small Group Work*. London: DCSF. RR064.

James, A. and Prout, A. (eds) (1990) *Constructing and Reconstructing Childhood: Contemporary Issues in the Sociological Study of Childhood*. London: Falmer Press.

Jessor, R., Van Den Bos, J., Vanderryn, J., Costa, F.M. and Turbin, M.S. (1995) 'Protective factors in adolescent problem behaviour: moderator effects and developmental change', *Developmental Psychology*, 31 (6): 923–33.

Jessor, R., Turbin, M. and Costa, F. (1998) 'Protective factors in adolescent health behaviour', *Journal of Personality and Social Psychology*, 75 (3): 788–800.

Koizumi, H. (2008) 'Developing brain: a functional imaging approach to learning and educational sciences', in M. Battro, K.W. Fischer and P.J. Lena (eds), *The Educated Brain*. Cambridge: Cambridge University Press, pp. 166–80.

Kolb, D. (1984) *Experiential Learning: Experience as the Source of Learning and Development* Englewood Cliffs, NJ: Prentice Hall.

Moran-Ellis, J. (2010) 'Reflections on the sociology of childhood in the UK', *Current Sociology*, 58: 186–205.

Muijs, D. and Reynolds, D. (2011) *Effective Teaching: Evidence and Practice*. London: Sage.

Murray, N.G., Low, B.J., Hollis, C., Cross, A.W. and Davis, S.M. (2007) 'Coordinated school health programs and academic achievement: a systematic review of the literature', *Journal of School Health*, 77 (9): 589–600.

Naidoo, J. and Wills, J. (2009) *Foundations for Health Promotion (Public Health and Health Promotion)*. London: Bailliere Tindall.

National Archives (2005) 'Social and Emotional Aspects of Learning (SEAL): improving behaviour, improving learning'. http://webarchive.nationalarchives.gov.uk/20110809101133/nsonline.org.uk/node/87009 (accessed 9 October 2013).

NICE (2007) *Interventions to Reduce Substance Misuse Among Vulnerable Young People (PH4)*. http://guidance.nice.org.uk/PH4 (accessed 9 October 2013).

Pashler, H., McDaniel, M., Rohrer, D. and Bjork, R. (2008) 'Learning styles: concepts and evidence', *Psychological Science in the Public Interest*, 9 (3): 105–19.

Prochaska, J.O. and DiClemente, C.C. (1983) 'Stages and processes of self change of smoking: toward an integrative model of change', *Journal of Consulting and Clinical Psychology*, 51: 390–5.

Prochaska, J.O. and DiClemente, C.C. (1984) *The Trans-theoretical Approach: Crossing Traditional Boundaries of Therapy*. Homewood, IL: Dow Jones Irwin.

PSHE Association (2013) www.pshe-association.org.uk/content.aspx?Category ID =1043 (accessed 8 October 2013).

Ruiter, R.A.C., Abraham, C. and Kok, G. (2001) 'Scary warnings and rational precautions: the psychology of fear appeals', *Psychology and Health*, 16 (6): 613–30.

Ruskin, J. (1853) *The Stones of Venice*, Volume 3. London: Smith, Elder & Co.

Singer, W. (2008) 'Epigenesis and brain plasticity in education', in M. Battro, K.W. Fischer and P.J. Lena (eds), *The Educated Brain*. Cambridge: Cambridge University Press, pp. 97–110.

Stead, M. and Angus, K. (2004) *Literature Review into the Effectiveness of Drug Education*. Edinburgh: Scottish Executive Education Department.

Stewart, D., Sun, J., Patterson, C., Lemerle, K. and Hardie, M. (2004) 'Promoting and building resilience in primary school communities: evidence from a comprehensive "Health Promoting School" approach', *International Journal of Mental Health Promotion*, 6 (3): 26–33.

Stewart-Brown, S. (2006) *What Is the Evidence on School Health Promotion in Improving Health or Preventing Disease and, Specifically, What Is the Effectiveness of the Health Promoting Schools Approach?* (Health Evidence Network Report). Copenhagen: WHO Regional Office for Europe. Available at: www.euro.who.int/document/e88185.pdf (accessed 21 May 2013).

Symons, C.W., Cinelli, B., James, T.C. and Groff, P. (1997) 'Bridging student health risks and academic achievement through comprehensive school health programs', *Journal of School Health*, 67: 220–7.

Tones, K. (1987) 'Health promotion, affective education and personal-social development of young people', in K. David and T. Williams (eds), *Health Education in Schools*. London: Harper Row.

UNICEF (2007) *Child Poverty in Perspective: An Overview of Child Well-being in Rich Countries*, Innocenti Report Card 7. Florence: Innocenti Research Centre. Available at: www.unicef.org/media/files/ChildPovertyReport.pdf (accessed 21 May 2013).

Weare, K. (2004) *Developing the Emotionally Literate School*. London: Paul Chapman Publishing.