A missing ethical competency? A review of critical reflection in health promotion

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Abstract

Issue addressed: There is increasing emphasis in the health promotion literature on the ethical imperative for the profession to move towards critical practice. A key challenge for health promotion is that critical practice appears both under-developed and under-practiced. This is evident in the omission of critical reflection from Australian and international competencies for health promotion practitioners.

Methods: A narrative literature review was undertaken to explore the current use of critical reflection in health promotion. Critical reflection models relevant to health promotion were identified and critiqued.

Results: There was a dearth of literature on critical reflection within health promotion, despite recognition of its potential to support critical practice. The discipline of critical social work provided literature on the use, effect and outcome of critical reflection in practice. The interdisciplinary critical reflection model was identified as the model most applicable to health promotion. Underpinned by critical theory, this model emphasises both critical and ethical practice.

Conclusions: Critical reflection is a core competency for health promotion practitioners to address the ethical imperative to move towards critical practice. There is a need to explore the application of a critical reflection model in health promotion to determine how it may support critical and ethical practice.

So what? If health promotion is to meet its ethical responsibilities, then critical reflection needs to be articulated as a core health promotion competency and a model for its application in health promotion developed.

Introduction

Critical health promotion is underpinned by values and principles of social justice, equity, holistic and ecological conceptions of health, empowerment, participation, salutogenesis, and evidence-based practice.1–3 As such, social change, challenging oppressive social power structures and dominant discourses and language, and applying constructivist principles of knowing and understanding are at the heart of critical practice.4,5 There is increasing emphasis in the health promotion literature on the ethical imperative to move towards more critical practice in order to address health inequities and the social determinants of health.6–8 Critical practice enables health promotion practitioners to focus on affecting the social structures that serve the interests of those who are the most powerful.5,9 It provides a lens for practitioners to view and understand these structures and how they contribute to inequities.10 Critical reflection provides a mechanism for health promotion practitioners to explicitly attend to the ethical values and principles of health promotion related to addressing health inequities.11,12

The Australian13 and international14 health promotion competency frameworks specify underpinning ethical values and/or principles, including addressing social determinants, empowerment, health inequities and social justice, which are critical in nature. Carter15 proposes that ethical practice involves practitioners ‘reasoning systematically about the right thing to do’ through thoughtful analysis of their practice. Health promotion scholars argue that although health promotion practitioners consider critical values and principles to be intrinsic to their work, they are often not made explicit or realised in practice.11,16 We propose that critical health promotion is ethically the right thing to do and that practitioners require a process to engage in such thoughtful analysis.
Critical reflection may offer the process and critical lens needed to support the profession to move towards more critical practice. For example, practitioners need a process to interrogate whether their practice challenges the social structures and systems that maintain health inequities. As a process, critical reflection has the potential to foster creativity, new ways of thinking and skill development in health promotion. To date, critical reflection has been used to strengthen the health promotion skills of those working in clinical settings, including nursing and palliative care. There is some acknowledgement of the potential use of critical reflection in health promotion and the need to explore its current application in practice. However, the adoption and explicit use of critical reflection in health promotion is yet to be fully explored.

The International Union for Health Promotion and Education accreditation system (available at http://www.iuhpe.org/index.php/en/the-accreditation-system, accessed 15 June 2014), which is based on the CompHP Core Competencies and professional standards for health promotion, does not include any reference to reflection or critical reflection. The Australian Core Competencies for Health Promotion Practitioners are predominantly technically focused (e.g. program planning, communication, and technology) and do not identify critical reflection as a competency. However, critical reflection is acknowledged as an important competency in other, arguably similar, disciplines.

Critical reflection is well developed in critical social work and may offer some learnings and guidance for health promotion. Critical social work and critical health promotion are aligned philosophically and technically in many ways, and both share a critical intent. Numerous values and principles are consistent across the two disciplines, including: a commitment to improved social justice and equality for those who are most marginalised, vulnerable and disadvantaged; actively working alongside those who are most affected by an issue; analysing and facilitating the redistribution of power that serves to marginalise and oppress particular populations; questioning dominant assumptions and discourses; and working towards emancipatory change at individual and societal levels.

Unlike health promotion, the social work discipline identifies critical reflection as a standard practice requirement. The Australian Association of Social Workers Practice Standards state that social workers should “apply critical and reflective thinking to practice” specifically to critically reflect on the role of the social worker and the broader organisational, societal and political context of practice.

Critical theory is the most appropriate framework to underpin critical reflection in critical health promotion because of its focus on bringing about social change. The grounding of critical reflection in critical theory distinguishes it from other forms of reflection. Critical reflection is concerned with questioning the underlying assumptions that shape society. Dominant discourses shape language, values, ideas and systems of truth within society, and are taken for granted and remain relatively unchallenged.

Critical reflection involves social and political analysis that enables transformative changes, whereas reflection without criticality is more descriptive and individualised. Applying this to critical health promotion means considering the broader structural determinants of health that go beyond individual behaviours. Therefore, critical reflection presents a challenge to traditional health promotion approaches that are underpinned by biomedical and behavioural health discourses. Critical reflection pays attention to power relationships and, as such, requires an understanding of and ability to challenge the structures of power that produce and legitimise oppressive and paternalistic practice. In critical health promotion, this relates to enacting values and principles that facilitate participatory and egalitarian processes. Critical reflection is committed to emancipation, which is consistent with the aims of critical health promotion to provide greater equity, empowerment, access and self-efficacy to those most marginalised, disadvantaged and vulnerable. Despite the consistencies between critical theory, critical reflection and critical health promotion, there is no definition of critical reflection in the health promotion literature that reflects this. In the absence of a definition, we propose the following:

Critical reflection is a continual process of assessing and challenging the underlying beliefs, values, assumptions, discourses and approaches to health promotion practice from the individual to the population level. This process aims to provide greater empowerment, equity, self-efficacy and access to those most marginalised, disadvantaged and vulnerable, and to challenge structural health inequities.

Using this definition, the aim of the present study was to ascertain the extent to which critical reflection has been explored in health promotion and critique the characteristics of critical reflection models relevant to health promotion. Such models needed to be grounded in critical theory to align with the social justice intent and values of critical health promotion.

Methods

The narrative literature review methodology described by Green et al. was used to compile an overview of critical reflection in the health promotion literature. Narrative literature reviews are used to present balanced perspectives on topics to initiate scholarly conversation. Relevant literature was identified through an electronic search of six online databases (Scopus, PubMed, Global Health, Cumulative Index to Nursing and Allied Health Literature (CINAHL), ProQuest Central, and Google Scholar), manual searching of reference lists and citations, a library catalogue search of relevant authors and critical reflection books and professional contact with an expert in applying critical reflection. Key search terms used in multiple combinations in all online databases included: critical reflective practice, reflection, health promotion, public health, health promotion practice, critical health promotion and critical social work.
Articles from any year were included up until December 2014. To be eligible for inclusion, articles had to discuss critical reflection as a way of developing professional practice, rather than as an educative tool. Articles that discussed reflection or critical reflection in health promotion were included, but articles from critical social work needed to have discussed critical reflection only. Articles were excluded if they were from disciplines other than health promotion or critical social work and/or focused on education or teaching of reflection or critical reflection.

The search identified five articles relevant to the development, application, or inclusion of critical reflection in health promotion. Early search results identified a critical reflection model supported by critical theory in the critical social work literature. This search identified a further six articles relevant to the model’s development, application, and evaluation. Of the total of 11 articles, seven were relevant to the critique of critical reflection models.

Each critical reflection model was assessed in reference to five characteristics of critical reflection identified in the literature. A score of 1 or 2 was allocated for each characteristic. A score of 2 represented a characteristic that was explicitly identified within the model and provided sufficient detail for this characteristic to be addressed by engaging in critical reflection. A score of 1 represented a characteristic that was implicitly identified within the particular model, but the model did not explicitly identify how this was to be achieved by engaging in critical reflection. Scores across the characteristics were summed. Higher scores represent greater explicit attention to the characteristics of critical reflection within the model.

**Results**

The results are presented in two sections: (1) the extent, effect, and outcome of critical reflection in health promotion; and (2) a critique of critical reflection models relevant to critical health promotion.

**Extent of critical reflection in health promotion**

There was a dearth of literature on the extent of the use of critical reflection in health promotion. Critical reflection was absent from Australian and international health promotion competency frameworks. Only three health promotion practice frameworks/models incorporated critical reflection as a key aspect of practice.

The Red Lotus Health Promotion Model is underpinned by critical health promotion values and principles that practitioners are required to critically reflect upon. The model incorporates a heuristic process that supports practitioners to critically reflect on the values and principles that underpin their practice. Practitioners are encouraged to reorient their practice if the values and principles are found to be inconsistent with best practice. However, the model does not explicitly provide a tool for engaging in critical reflection.

Kahan and Goodstadt emphasised the importance of engaging in critical reflection as a key component of their Interactive Domain Model of Best Practice in Health Promotion. This model identifies a range of components across the health promotion planning cycle that characterise health promotion best practice. Engaging in critical reflection across all components is required to ensure that best practice is applied. Although the model identifies the importance of questioning underlying assumptions, it appears to be more pragmatic than critical. It does not focus on enacting change in the structures and power relationships that often impede the adoption of critical health promotion.

Fleming supports reflective practice as a key professional skill for health promotion practitioners. Through the development of the Typology for Reflective Practice in Health Promotion, he addresses the need for a flexible and structured framework to support practitioners to reflect on the role of ‘self’, the ‘context’ and the ‘process’ of health promotion program planning. Fleming also expresses the potential of reflection to promote critical consciousness and inform the development of health promotion. Although the typology may enable a practitioner to explore their practice from a critical perspective, this is dependent on the practitioner(s) posing critical reflective questions within each domain. If practitioners do not have a critical understanding, then the reflection they engage in is not necessarily critical.

**Effects and outcomes of engaging in critical reflection**

There was also a dearth of literature on the effects or outcomes of critical reflection in health promotion. The proposed positive impact of critical reflection on professional practice through a renewed sense of agency and the identification of opportunities for change was not documented. Social work offered some findings on the effects and outcomes of engaging in critical reflection, but this literature was predominantly focused on what happened during the process of engaging in critical reflection; for example, what opportunities for change were identified, what assumptions were unearthed that could impact practitioners’ practices and what renewed sense of agency or power practitioners envisioned.

There was very little empirical research that documented the benefits and outcomes of critical reflection in a systematic way. The exception to this is the work of Fook and Gardner. These authors identified four themes related to the benefits and outcomes of participating in their critical reflection workshops, including: rationality (more considered and evidenced-based action taking); self and the emotions (greater awareness); value-based practice (more inclusive, less judgemental practice); and practice and skills (better sense of professionalism). Gardner explored the longer-term outcomes of engaging in critical reflection by interviewing 20 participants at least 1 year after they had completed a critical reflection workshop. The results indicated that over half these participants reported understanding the critical reflection processes, an awareness of multiple perspectives, a greater
sense of self and the effect of self on practice, a greater awareness of underlying assumptions and values, more openness in relationships, specific changes in behaviour and the transferability of critical reflection skills. However, the results were inconsistent in terms of whether the process had influenced organisational change.36 The study did not measure social or structural changes, which are arguably the drivers for engaging in critical reflection.

Morley contends that further research is required to identify whether practitioners act on new opportunities for change and whether greater awareness of their practice and improved agency leads to improved practice.7 This may lead to research that determines the effects of engaging in critical reflection on broader social and structural changes, which ultimately lead to improved health and well being for those who are most marginalised, vulnerable and disadvantaged.

Critique of critical reflection models and frameworks relevant to health promotion

Three critical reflection models were identified as being relevant to health promotion: (1) the Typology for Reflective Practice in Health Promotion (hereafter referred to as the ‘Typology Model’);20,21 (2) the Critical Reflection Model (CRM);4,30 and (3) the Critical Reflection Model (adapted version) (CRMa).9,33,34 The Typology Model provides a process for practitioners to reflect on their practice by posing questions across each of the three domains (self, process, context). The model is designed to be applied before, during or after a program’s completion with individual practitioners or in teams.20,21

The CRM is an interdisciplinary model that has been used in social work, nursing and education.30 The purpose of the CRM is ‘to unsettle the fundamental (and dominant) thinking implicit in professional practices, in order to see other ways of practising’.30 The CRM is underpinned by critical theory, postmodernism, deconstruction, reflexivity and reflection.30 It is applied in small groups where practitioners are guided through two reflection stages (deconstruction and reconstruction).30 The CRM involves creating practitioners’ awareness of their social context, using critical reflection to understand and reinterpret experiences, and link this new awareness with options for change.30

Morley expanded the use of the CRM by using it as a method of inquiry with social work practitioners that supported sexual assault victims through the Australian legal system.33,34 This application (CRMa) with individual practitioners resulted in connecting them with their sense of agency and enabled them to envision the power to bring about change even in the most disempowering contexts.9,34 The CRMa was applied using the line of questioning and theoretical underpinnings of the CRM.9

The characteristics of critical reflection that are underpinned by critical theory and the extent to which each model represents each characteristic were identified (Table 1). Overall, the CRM and CRMa were allocated the highest scores, indicating the greatest explicit attention to the characteristics of critical reflection. All three models included the development of a range of questions to guide the critical reflection process. The questions were based around a particular component or ‘lens’ (Table 2). As a result, if the practitioner using the model does not pose critical questions, they are potentially not engaging in critical reflection.

All models acknowledged the importance of questioning dominant assumptions and discourses as a key component of critical reflection. The assumptions and discourses in each model were influenced by their theoretical framework. The CRM and CRMa are influenced by

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<tr>
<th>CR model or framework</th>
<th>Theoretical underpinning</th>
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<th>Social rather than individual focus21</th>
<th>Power relationships21</th>
<th>Emancipation for the individual engaged in CR21</th>
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<td>Typology for reflective practice in health promotion4,21 CR model4,30</td>
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<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>6</td>
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<td>Critical postmodernism, deconstruction, critical social theory, reflexivity, reflective practice4,30</td>
<td>2</td>
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critical theory and postmodernism. The assumptions unearthed through the use of these models often relate to power and its various constructions, ways of knowing, cultures and subcultures, and the role of language and discourse. This is significant for critical health promotion because biomedical and behavioural health discourses often dominate holistic and ecological conceptions of health in day-to-day practice. This is significant for critical health promotion because biomedical and behavioural health discourses often dominate holistic and ecological conceptions of health in day-to-day practice. 

All three models recognised the need to question and challenge power and its various forms. When critically reflecting on power, it is most commonly associated with its effect on the practitioner’s sense of agency and how they contribute to their own implicit assumptions about power and their ability to change it. The CRM and CRMa place significant emphasis on exploring practitioners’ views, ideas and assumptions about power, with the aim of empowering the practitioner to see other possible interpretations of their own power. In critical health promotion, critical reflection should also attempt to empower those who are most marginalised, disadvantaged and vulnerable. The CRM and CRMa address this characteristic through their line of questioning, which requires the practitioner to critically reflect on how ‘others’ are potentially affected by power imbalances. Although the Typology Model acknowledges the importance of power, it is focused on the power relationship between the health promotion practitioner and the population they are working with and/or studying. It is crucial that health promotion practitioners strike a balance between connecting with their own sense of agency to challenge traditional approaches to practice and ensuring that their own power to plan, implement and evaluate health promotion initiatives does not further disempower those who are already marginalised, disadvantaged and vulnerable, and who may, indeed, be supportive of such traditional approaches to practice.

Through a focus on acknowledging dominant assumptions and power relationships, each model recognises that critical reflection must go beyond thinking about the individual and consider the broader social context that impacts on people’s circumstances. The CRM and CRMa both aim to reveal the individual’s understanding of their social world, how this impacts on their professional practice and identify renewed ways of practising in order to bring about social change. The Typology Model acknowledges the importance of considering societal influences on health promotion practice through its ‘context’ domain. This includes considering assumptions, values and sociocultural factors, but it does not explicitly connect identifying these characteristics with opportunities for making changes to them. Without this connection, it is uncertain whether health promotion practitioners would be able to envision opportunities for change.

### Discussion

The present narrative literature review set out to explore the extent, effect and outcome of critical reflection in health promotion and critique relevant critical reflection models. There were significant difficulties in identifying and critiquing current literature on the extent, effect and outcome of engaging in critical reflection because of the diversity of definitions of critical reflection, the models and frameworks that guide it and the unpredictability of how the process is experienced by different learners.

The review identified that despite the acknowledgement that practitioners should critically reflect on their practice, the Typology Model is the only model that articulated a process for engaging in critical reflection. However, critical theory is absent from this model, which results in significant expectations on practitioners’ critical understanding if they engage in critical reflection. The CRM and CRMa provide a process for engaging in critical reflection and make explicit reference to critical theory as the underpinning theoretical framework, but neither has been used in health promotion (at least as described in the literature).

All three CRMs meet the five characteristics of critical reflection by explicitly identifying them within the model. Although the Typology Model identifies each characteristic, it does not explicitly identify how four of them are to be addressed by engaging in critical reflection. The CRM and CRMa both explicitly identify and provide a process for addressing all five characteristics and therefore have potential to be applied in health promotion.

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**Table 2. Components of each model that guide critical reflective questioning**

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<tr>
<th>Model</th>
<th>Purpose</th>
<th>Components/lens</th>
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| Typology for reflective practice in health promotion | To pose a range of reflective questions to practitioners, regarding self, context and process | The self (individuals and teams) in program planning  
The context (socioeconomic and other environmental and political factors) in program planning  
The process in program planning and delivery |
| CR model                      | To unearth fundamental assumptions implicit in practitioners’ accounts of their practice and to consider what changes could be made as a result of this new understanding | Deconstruction  
Reconstruction |
| CR model (adapted version)    | As above (applied with individuals in a research context)              | Deconstruction  
Reconstruction |
Practising critically in health promotion is crucial for the profession to meet its ethical responsibilities.\textsuperscript{6-8} A commitment to social justice, empowering and participatory processes, evidence-based practice and addressing inequities are all well-recognised values and principles underpinning critical health promotion practice.\textsuperscript{3,11} Despite the growing recognition of critical practice in the literature, it appears both under-developed and under-practiced in health promotion. This is reflected in the omission of critical reflection as a key competency from both the Australian and international health promotion competency frameworks, despite the inclusion of critical values and/or principles in their ethical principle component.\textsuperscript{12,14}

As in critical social work, critical reflection has been identified as a process that could assist the health promotion profession move towards more critical practice. Current evidence suggests that critical reflection has not been fully explored in health promotion. However, critical reflection has been applied effectively in critical social work, including the development of the CRM and its use as a method of inquiry (CRMa), which is aligned theoretically with critical health promotion. There is a need to explore the development of a critical reflection model for health promotion to ensure that the critical intent of health promotion practice is realised.

**Conclusion**

Critical reflection is a key component of critical practice. Not engaging in critical reflection runs the risk of reinforcing and/or not challenging dominant discourses and oppressive power and social structures, and thereby not addressing inequities and the social determinants of health. If health promotion is to uphold its ethical values, then critical reflection needs to be articulated as a core competency for health promotion practitioners. Although the CRM provides a potential foundation, further research is required to develop a critical reflection model for application in health promotion.

**References**


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