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The Role of Self-Directed Learning in Older Adults' Health Care

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Keywords: Self-directed learning, older adults, health care

Abstract: This descriptive study expands the understanding of the impact of self-directed learning (SDL) on older adults' health care. Findings reveal motivating and controlling factors that influence learners, identifies a SDL process specific to health care, offers insights into the perceptions older adults' hold, and barriers they encounter.

Introduction

The U.S. population is comprised of 35 million adults aged 65 and older. By 2030, the number of older adults will have doubled to 70 million, or one in every five Americans (National Center for Chronic Disease Prevention & Health Promotion, 2002). Commonly, older adults are the most frequent users of medical services and their growing numbers are placing increasing demands on medical and social services in the U.S. In the United States, almost one-third of today's health care costs, \$300 billion each year, is for older adults. Chronic diseases exact a heavy health and economic burden on nearly 40% of the older adult population living within the community due to associated long-term illness, diminished quality of life, and greatly increased health care costs (National Center for Chronic Disease Prevention & Health Promotion, 2002). In addition, older adults' health is often compounded by multiple health conditions and adjustments to later life events such as deaths of spouses, partners, friends, and loved one, loss of homes, financial challenges of retirement years, and societal changes (Deluca & Enmar, 2001; Neugarten, 1996; Roberson, 2003).

In response to the increasing numbers, costs, and health care needs of older adults, the medical establishment has changed patient-care policies. For example, managed care provider reimbursement policies have created incentives to move patients quickly through the health care system and have pressured physicians to limit office visit time for dialogue and health education. In response to these changes, health educators have been promoting an active role for the patient in their own health care (Berman & Iris, 1998; Keller & Fleury, 2000; National Centers for Chronic Disease Prevention & Health Prevention, 2002).

The importance of understanding factors contributing to health maintenance is especially relevant for older adults, as it is this segment of the population who typically face the greatest health risk. Older adults who have taken control of their health care are self-directing their own learning. However, little is known about how older adults are using self-directed learning to gain access to health information and how this information is affecting their health care.

The purpose of this study was to further the understanding of the role of SDL in older adults' health care. The research questions that guide this study are as follows:

1. What motivates older adults to take control of their learning regarding health care?
2. What health care behaviors are controlled by self-directed learners?
3. What contextual factors are controlled by self-directed learners?
4. What is the process of SDL of one's health care?
5. How does SDL affect one's health care?
6. What barriers do learners experience in the self-direction of their health care?

Four bodies of literature inform this study, including: the U.S. health care system self-care, SDL, and SDL related to older adults. The literature related to the health care system provides the foundational information and sets the stage for the study by identifying the key issues within the system that contribute to the older adult taking control of their health care. A review of self-care as a health care option for older adults provides a philosophical foundation from which to build a relationship between health, education, SDL and older adults. Lastly, the review of SDL literature grounds the study in the field of adult education.

Theoretical Framework

The epistemological frames for the study are rooted in constructionist philosophy with the intention of understanding the learning process that ultimately affects personal health. According to Crotty (1998), in the constructionist view, truth or meaning comes into existence through our engagement with our world of reality. "It is the view that all knowledge and all meaningful reality is contingent upon human practice, being constructed through interaction between human beings and their worlds, and developed and transmitted within their social context" (Crotty, 2003, p. 42).

Few other issues in life require such diligent meaning making than those affecting personal health. Meaning may be derived from social interactions and is handled through an interpretive process (Sandstrom, Martin, & Fine, 2001). Individuals faced with illness seek information from health care professionals, support groups, friends, written materials, the Internet and other sources to enhance their understanding about the management of their health. Their careful interpretation of what they learn is used to make health and treatment decisions. This study provides new understanding of how older adults interpret their experiences, construct their worlds, and make meaning of their experiences as they self-direct their learning.

Methodology

Informed by the theoretical perspective of constructionism and the interpretive process, the design of this study is a basic qualitative study. Qualitative research is an inductive model of knowledge inquiry (Merriam, 2002; Patton, 2002), with the intent to gain greater understanding of the lived experience, in this case, of older adults self-directing their health care. A criterion based, purposeful sampling approach was employed to identify 15 older adults for the study. These criteria included: (a) be age 65 and older, (b) have had a health condition or illness for a minimum of 6 months, and (c) can offer some evidence that they are involved in SDL to manage their care.

The primary methods for data collection included the use of semi-structured and open-ended interviews and collection of documents. Interviews (45-60 minutes) were audio taped and transcribed by the researcher using the constant comparative method (Strauss & Corbin, 1998). Documents comprised of a variety of different materials used by the participant to manage their health. To enhance internal validity, methods triangulation, member checks, peer examinations, investigator's position and audit trail strategies were conducted to ensure consistency, dependability and reliability of the data. External validity was enhanced by providing rich descriptions of findings, using purposeful sampling methods choosing diverse participants.

Findings

The fifteen participants range in age from sixty-five to eighty-nine. Eight are female and seven are male. Seven of the females are white and one is African American. Three of the males

are white and four are African American. Of the eight females, four live in Georgia and four live in Texas. The males all reside in Georgia. The participant educational levels ranged widely from grade four to a doctorate degree. A high school diploma was the highest level of education for three of the women. Three women have bachelor's degrees, and two hold master's degrees. Three of the men have not completed high school. One male did not graduate from high school, but later acquired his G.E.D. One male had acquired his bachelor's degree, one his master's and one had a doctorate. The majority of the participants had retired from their former professions. Only two women remained employed in their privately owned business endeavors. A variety of professions were represented including teacher, real estate broker, minister, military professional, nurse, accountant, mechanic, maintenance person, taxi driver, business owner, and homemaker. As for major health issues, five of the participants have high blood pressure. Three report having heart problems. Three had experienced a major stroke, resulting in two of the three using wheelchairs directly due to stroke. Balance issues and walking posed a major health issue for two participants. Diabetes, arthritis, osteoporosis, multiple myeloma, and polymyalgia rheumatica were also among the major health issues found within this group of older adults.

Based on the analysis of the research questions, six key factors and associated themes were found that related to understanding how older adults' SDL is affecting their health care. These six key factors are: (a) Factors that motivate older adults to take control of their health by using SDL are related to age related issues, other people, and the potential benefits. (b) Health care behaviors controlled by self-directed learners include: establishing appropriate physical activity and exercise levels, maintaining positive psychological health, and managing the specific health condition. (c) Contextual factors controlled by self-directed learners are their living, public and social environments. (d) There is a learning cycle of self-directed health care. (e) Perceptions of the effect of SDL on older adults' healthcare are that it reduces threats to health, raises body awareness and sensitivity and increases collaborative management of their health care. (f) The barriers learners experience in self-direction of their health care are due to physical limitations, environmental limitations, policy regulations, and personal management issues.

Motivating Factors

The older adults in this study recognize the connection between aging and health. They understand the importance of managing their health care since they were all involved in coping with a variety of health conditions and issues. Age related issues of health, heredity, and awareness of mortality motivated these adults to take control of their health by using SDL. Genetic predisposition to specific illnesses alerts the self-directed learner to their increased potential for specific diseases. This awareness motivates the learner toward conducting SDL activities that results in their incorporating behaviors that help to maintain good health. Finally, an understanding of the relationship between health and mortality serves to stimulate and accelerate SDL.

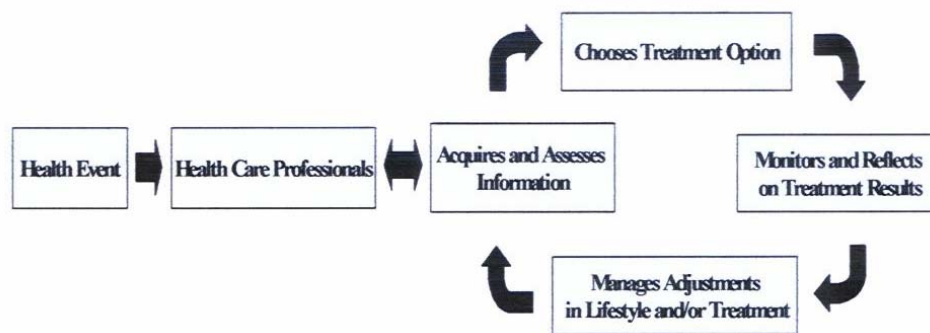
Older adults are also motivated to take control of their health care through SDL by contact with others including: health care providers, family, friends, and their belief in a higher power. The potential benefits of taking control of learning about their health care through SDL served to motivate the participants toward achieving personal health goals such as weight control, exercising, regaining strength, and blood pressure control. Recognizing that one's health can affect independence is perhaps one of the most important reasons driving proactive involvement in the self-direction of one's health care for the participants of this study.

Overwhelmingly, the older adults in this study possess positive outlooks about their health. One study participant, Randy believes that managing health is “making a plan to live” rather than making a plan to die. He explains, “this plan for living should incorporate realistic preventative measures of health management suited to the individual’s needs.” The findings reveal that to manage health conditions using SDL requires a variety of procedures and activities incorporated into the daily lives of these older adults such as controlling diet, monitoring conditions, managing medications, and using assistive devices. The self-directed older learner establishes health behaviors that target and manage their specific health condition based on the individual’s level of physical and psychological strength. These activities are enhanced by a positive outlook on life, which helps to facilitate better health and well being.

Contextual Factors Controlled by the Self-directed Learner

The contextual factors controlled by older adults’ SDL include both their personal living environment and their public/social environments. Participants in this study choose to live in accessible homes that meet their current and future needs. They associate with positive people. Group functions held at the churches, clubs or senior centers contribute to their well being by providing opportunities for social interaction, health education, spiritual inspiration and volunteerism.

Figure 1. The Learning Process in Self-directed Health Care



The figure above shows the self-directed health care process. The SDL process involves negotiation and socialization as older adults manage their health care. This process is triggered by a health event, which acts as an impetus to move individuals through the cycle of learning. Thus, the learner then moves forward, as illustrated by the arrow pointing to the right, to contact their health care professional seeking confirmation and diagnosis of their health condition. This learning cycle is learner initiated; typically, this occurs immediately after the individual receives a diagnosis. From this point, the learner moves to acquiring and assessing information, choosing treatment(s), monitoring and reflecting on the result of treatment interventions, and managing adjustments in their life style and treatment(s). The arrow between the health care professional and the cycle of learning is two sided, pointing in both directions. This reflects that during the process of learning, the learner moves forward into the cycle of learning and then typically moves back to collaborate with their health care professional for additional information. This process and cycle of learning occurs continuously as health events emerge.

Perceptions of the effect of SDL on older adults' health care

Older adults participating in this study perceive that one can reduce the threats to their health by being actively involved in SDL regarding their health care. What older adults actively involved in SDL learn helps them to take charge and control their specific health issues with a new sense of awareness and sensitivity about their health. They often choose to examine a variety of educational resources to determine, evaluate and understand treatment options. This information allows the self-direct learner to become more informed about their health care issues and facilitates and enhances collaborative working relationships with their health care professionals.

Barriers Learners Experience in the Self-direction of the Health Care

Learners do experience some challenges associated with self-directing their health care. Physical limitations such as difficulty walking, changes in balance, weakness and exhaustion, vision problems coupled with the normal changes associated with aging can become barriers to self-directing one's health. Environmental issues such as greater difficulty in navigating outings when encountering inclement weather, the learning environment, other people, and the living environment creates challenges to self-directing one's health. Additionally, changes in regulations and new policies in medical care can limit services and challenge management of one's health. Finally, personal management issues such as procrastination, frustration, laziness, and managing depression, worry and fear can become barriers to self-direction of one's health.

Conclusions

Three conclusions regarding how older adults utilize SDL to impact their health care can be drawn from this study. First, older learners are motivated to take control of certain aspects of their health care. Second, the SDL process specific to health care involves negotiation and socialization. Third, self-directed behaviors are perceived by self-directed learners as positively affecting health care.

This study provides new insight into the lives of older adults who are involved in self-directing their health care. The positive attitude and enthusiasm for life reflected throughout the study's interview conversations provided a remarkable illustration of the strength and fortitude that older adults engaged in SDL maintain regardless of the number and severity of the health issues they are managing. The stories provided by these self-directed learners offer insight into a new and hopeful relationship between health, learning, and quality of life issues.

Implications for Practice

The results of this study provide practice implications for gerontologists, social service workers, health, housing, and adult educators as they are all engaged in providing learning opportunities for older adults that encourage them to take control of their lives. According to Healthword (2004), "health promotion for older adults doesn't just mean teaching elders about healthy behaviors, it means motivating them to change" (p. 1). Motivation for healthy living begins with making a personal commitment to improving one's health combined with a wide range of other motivators such as an event, friends, mentors, beliefs, culture, and environment. Since self-directed learners also rely on these motivators, it is important to provide opportunities for learning that incorporate these factors into educational programs targeting older adults. Educators must realign our view of older adults from patients to self-healers (Blueprint for

Health Promotion, 2004). Self-healing connotes that these adults are becoming self-directed in their approaches to management and control of their health. However, there is the potential for learners to get the wrong information that could result in negative health outcomes. Therefore, as adult educators it is important to recognize this potential for harm by making recommendations that encourage ongoing consultations with their health care professionals. The emphasis on self-responsibility for health by the medical establishment reinforces the importance of what adult educators can do to empower seniors through their educational efforts. Furthermore, there is a gap between medical specialists and lay knowledge. The adult educator can play a key role in closing this gap by working in collaboration with health professionals designing appropriate and culturally sensitive training events and materials. In addition, older adults need to be made aware of the potential benefits to their health by using SDL.

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