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Adult Education for Health and Wellness: A ‘State of the Field’ Review of Emergent North American Literature

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Abstract: Learning about health takes place in a variety of ways over the course of one’s lifetime; adult education can play a key role in enabling individuals, communities, and societies to maintain and improve their health. This paper focuses on emergent research in adult education related to health and wellness.

Although much is known about the wide range of health determinants—biology and social factors—little practical consideration has been given to the role of adult learning in these processes, and ways that change in health can come about. Health professionals are therefore turning to adult education to increase their understanding of the links between health and learning, and adult educators are responding by exploring these many links. This paper highlights the growing body of literature within adult education related to health and wellness. The paper first profiles the nature of conversations that are being taken up by adult educators, including transformative educators. The second part focuses on emergent research in this area related to program planning, teaching and learning.

Emerging Health Research from Adult and Transformative Education

A preliminary review of North American learning literature reveals that adult educators are contributing significant knowledge on teaching and learning for health. For example, Baumgartner (2011) examines the role of adult learning in coping with chronic illness, profiling research studies of self-directed, informal, incidental learning. Stuckey (2009) explores how women make meaning of and cope with chronic illness. She uses action research and arts-informed methods to acknowledge multiple ways of knowing and to help the women express themselves and to learn from the research. Arts informed research extends to how multi-media exhibits communicate the emotional complexities of Alzheimer’s disease and what it means to care (Cole & McIntyre, 2007). Others are exploring health literacy contexts, extending knowledge beyond a focus on basic literacy skills, to how individuals obtain, process, and understand the basic health information required to make appropriate health choices (Gillis & Sears, 2012).

Transformative learning theory is providing a lens for examining learning and change in health contexts. For example, Courtenay, Merriam, Reeves, & Baumgartner (2002) write about HIV/AIDS and transformative learning resulting from the illness, and Bliss (2004) describes how opportunities for meaningful learning and community service (e.g., Elderhostel, Coming of Age Coalitions) help individuals over 60 to regenerate and reinvent themselves in retirement. Others like Lyman (2009) focus on transformative learning theory in the training of health professionals to enact understandings of the complexity of health determinants and conditions that contribute to growing health inequalities. Others, as critical researchers, examine the implicit underlying assumptions either of learning or teaching, and the potential for dominant ways of knowing to

create and reinforce conditions that constrain health (English, 2012 and Labonte, Muhajarine, MacIntosh, & Williams, 2005). English, for example, advances a critical theory of adult health learning integrating critical theory with critical adult education processes to increase awareness and action on the social determinants of health. Tett (2001) reports that community-based learning that engages people in critically examining their health beliefs and the social context of their health can lead them to want to take action on the conditions that contribute to their poor health. The emergent literature in the areas of program planning, teaching and learning, and research bear on both individual and community health issues, and on the implications of this research for educational planning and practice.

Program Planning

There is increasing demand for information and programs that support individual change in health behavior or community-oriented change at a broader level (Schechter & Lynch, 2010). This broader focus extends beyond individual healthier lifestyles toward creating learning environments and conditions whereby individuals can learn and contribute to social action (Coady, 2013; Hill & Ziegahn, 2010). Adult educators, therefore, are increasingly exploring how best to plan educational programs that support learning at both of these levels. Cervero and Wilson (2006), for example, see educational planning less as a process of the sequential execution of planning steps but rather a social activity of negotiating interests in relationships of power. They acknowledge the powerlessness people often experience as a result of their socio-cultural and economic conditions, and the need for education programs to address these conditions, for successful learning to occur. To the extent that educational interventions enable adults to overcome factors that constrain their learning, they are envisioned to be able to learn and to exercise more control over their health choices (Schechter & Lynch, 2010). However, Chovenac and Foss (2005) caution that poor socio-economic conditions that contribute to poor health are likely to persist as long as the structures that build and maintain them exist.

Despite these constraints, Hill (2011) highlights a role for educational planners. She argues that, although educators do not have control over many factors that inhibit people's learning, they can help tailor programs that are more responsive to people's needs, beliefs, and values. Health studies confirm the importance of acknowledging these characteristics and conditions. For example, in a study of young people with chronic disease, Stewart & Dearmun (2001) found that acceptance and adherence to health information was strongly linked with the educator's ability to acknowledge the unique challenges for youth in this context, and to incorporate their personal and cultural identities and worldviews into the learning activities. According to Hill, curriculum that is based on the experience and needs of adult learners can be more effective in conveying needed information and helping adults see the necessity of behavioral or lifestyle changes.

It is impossible to discuss learning about health without discussing health literacy. Health professionals and educators are increasingly aware of health literacy as a determinant of health and a consideration in educating adults about their health. As a starting point, basic literacy is an issue. Yet, health literacy is not just about basic literacy; people who function well in literacy contexts may struggle with decoding health care messages due to the unfamiliar terminology and concepts (Hill & Ziegahn, 2010). Health literacy is also not just about knowledge, but rather embedded in people's concepts and their notions of impact and action both for themselves as

individuals and for social norms (Rootman & Gordon-El-Bihbety, 2008). The potential impact of health literacy knowledge, or lack thereof, is greatest among vulnerable populations (e.g., persons with low literacy, seniors, women, immigrants, the unemployed, persons living in remote rural areas, and those with HIV/AIDS) who are constrained by poverty and other structural constraints, and generally less healthy and less able to take action on their health. Educational researchers and planners are therefore studying creative strategies and educational approaches to increase health literacy levels, particularly among vulnerable population groups. One area they are examining is how improving access to health programs, information, and services can improve levels of health literacy. For example, Pleasant (2011) studied programs that incorporated health topics into literacy programs. ESL students were able to access clinic-based individual and group health education sessions with a health educator offering literacy education on specific health topics. The health professional also provided monthly instruction in the ESL classroom focused on literacy and general health, and helped learners access blood pressure, cholesterol, and glucose screening through bi-monthly mobile van visits to the ESL program. In these studies, the levels of health literacy among ESL students were significantly enhanced; they reported being more able to navigate health services and information and to make more informed decisions about their health.

Fostering a high level of awareness and instructor capacity and confidence is also essential in achieving higher levels of health literacy, and educational planners and researchers are examining innovative ways to build their knowledge and capacity. For example, Diehl (2011) studied a study circle model used to support health literacy skill development with literacy, and other adult education instructors. They studied health topics (chronic disease, health promotion/disease prevention, and screening activities) with health care professionals and brought this knowledge back to the classroom in their curriculum. Diehl discovered that the instructors benefited from receiving support from health professionals; they reported feeling more knowledgeable and confident about teaching literacy skills in a health context. Learners also reported increased health knowledge, and a capacity to apply it to their day-to-day living. The consultation with literacy experts enabled the medical professionals to increase their understanding of health literacy and to apply this knowledge in their clinical settings. These studies highlight the value of an adult learning perspective in planning programs that foster learning about health. The adult educators' concern with the processes of learning, and addressing the influences that inhibit learners from accessing and using health resources, is vital if educational programs are to empower people to solve health related problems at the individual and community levels.

Teaching and Learning

Adult educators are developing teaching and learning strategies that foster learning about health. They are discovering that adults differ in their responsiveness to illness and the processes of learning, and have distinctively different needs and preferences when it comes to learning about their health (Kinsella, 2009). They are finding that adults use a variety of resources to learn about their health (e.g., print materials, educational seminars, Internet, networking, one-to-one conversations), and may prefer to learn on their own or in interaction with others. For example, Baumgartner (2011) cites a study of multiple sclerosis (MS) patients who preferred to learn informally, and in a self-directed way in reading and talking with doctors, and living with MS.

They avoided MS chapter lectures and group counseling because they did not want to see others worse off than themselves. In a companion study, Clark et al. (2009) found that women living with cardiac disease had a preference to learn in groups rather than through self-directed learning because the social support in a group program provided a structure for meaning making and support through emotionally challenging content. Yet others preferred to learn informally in community settings where they could learn about health in the context of their everyday lives. Goanna-Golding (2011) for example, found that older Australian men (50+) navigated learning about health and aging issues through informal dialogue. Others prefer to learn about health in faith-based based settings (Rowland & Chappel-Aiken, 2012).

Jackson (2006), in examining the relationship between lifelong learning and lifelong illness, found that learning needs and preferences often change over time. From his research with people living with primary immunodeficiency (PID) he found that although they were initially too ill to participate in compulsory post-diagnosis education, they later sought out more formalized opportunities for learning about their illness. These studies highlight the importance of developing instructional strategies in response to the different learning styles and preferences of individuals and groups. They also reinforce the value of a learner-centered approach that places the experience and needs of the learner at the center of the educational intervention/program. Strategies that support a learner-centered approach include discussion and dialogue with learners about their goals, and structuring learning experiences that apply to their lives (Schechter & Lynch, 2010).

Studies reveal the central role of emotion in learning about health, and living with a chronic disease. Yet, studies reveal that emotional needs are often not adequately addressed in these processes of learning about our health (Rager, 2009). Educational researchers are therefore examining the impact of emotions and how they might be addressed in the teaching–learning transaction. Lynn (2001) for instance, used learning journals and discussion to help adults to go beyond identifying what they were feeling, to understanding the sources and underlying assumptions of their feelings, in order to manage the effect of their emotions on their learning, and Dirkx (2001) explored how emotional and affective dimensions of learning can contribute to a positive educational experience. In this context, learning can be transformative, involving larger changes in the person than simply gaining information (Hill & Ziegahn, 2010). Whether learning is self-directed or other directed, individual or collective, when it involves people looking at the assumptions underlying their beliefs and forming new more inclusive worldviews, the learning is transformative (Mezirow, 2009).

Transformative learning theory is a helpful contributor to understanding the experience of learning in a variety of health contexts. For example, diagnosis of illness can be a disorienting dilemma that leads people to critically reflect on their assumptions about the world and eventually to integrate the illness into their identity over time. The studies of Courtenay et al. (2002) affirm that although HIV/AIDS patients initially had a strong negative emotional reaction, over time they were able to assimilate the disorientation brought on by their diagnosis into their identity, and to envision a new role for themselves in helping others with HIV/AIDS. This consolidation into a new meaning perspective promotes continued meaning-scheme changes, which includes having a sense of the future, greater care for the self, and an increased integration of illness into their identity (Baumgartner, 2011). Such studies of transformation

provide a basis for developing strategies to foster learning and transformation as adults learn about their health, and to live well with illness.

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