Adult Health Learning and Transformation: A Case Study of a Canadian Community-Based Program

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Abstract
This article describes a case study of adult learning in a Canadian multisite Community Cardiovascular Hearts in Motion program. The researcher highlights the informal learning of 40 adult participants in this 12-week community-based cardiac rehabilitation/education program in five rural Nova Scotia communities. The effects of this learning and barriers are examined, along with aspects of program design and facilitation that support learning and transformation. The researcher points to the role of emotion in this transformative learning process, and links are made between individual and collective processes in the transformative learning. Transformative learning theorists and health and adult education practitioners can see in this case study how individual and collective health interests can be incorporated into program planning for the community.

Keywords
adult education, transformative learning, community health, community development

In the Western world, including the United States and Canada, people often have a great deal of information on health but less on the links between health and adult learning. Researchers are aware that health and wellness depend on individual motivation, as well as support from a variety of interpersonal, community, and institutional sources (L. Hill & Ziegahn, 2010). Yet many challenges remain in understanding how to enable learning that leads citizens to exercise more control over their health. Much is known about a wide range of health determinants—biology and also social factors beyond the individual, including societal structures, geography, income, and ethnicity—but little

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practical and theoretical consideration has been given to the role of adult learning in these processes (Bryan, Kreuter, & Brownson, 2009; Feinstein, Hammond, Woods, Preston, & Bryner, 2003). Furthermore, many existing theories do not fully integrate a systematic adult learning component or address ways whereby change can come about (English, 2012; Quigley, Coady, Grégoire, Folinsbee, & Kraglund-Gauthier, 2009; Stuttaford & Coe, 2007).

To inform an understanding of adult health learning (see English, 2012) in this context, this article provides a case study of adult learning in a Community Cardiovascular Hearts in Motion (CCHIM) program in five rural communities in Nova Scotia, Canada. The study provides insight into areas where health and learning overlap. The applied learning focus in adult education provides a way of exploring participants' experience to discern how and what they learn, how they are motivated, and how learning that leads to action can be supported. This article reports on these elements in the CCHIM program and on aspects of program design and facilitation that stimulated the informal and often transformative learning that led to an increased sense of control and well-being among participants. The adult education literature (e.g., UNESCO, 1999) reinforces that informal learning in nonformal health education programs can be transformative and lead to significant improvements in health and general well-being.

An increasing number of scholars are acknowledging that adult learning dimensions are underexplored in the health education literature (Bryan et al., 2009; English, 2012; L. Hill & Ziegahn, 2010). There is a clear need to deepen educators' understanding of informal learning in health settings and the related teaching and facilitation considerations, especially the implications of transformative learning theory (Mezirow, 2009) when programs are delivered by health care teams in community settings. Community-based delivery has long been advocated as a strategy for achieving population-level change in risk behaviors and health (Merzel & D’Affitti, 2003). This focus on community- and population-based health determinants has evolved in recent decades and represents a shift in emphasis from individually focused explanations of health behavior to one that encompasses social and environmental influences. Yet researchers have limited knowledge of how learning about health is encouraged and inhibited in community.

The Health Development and Education Context

Adult learning has been documented in the health literature as a central dimension in educating populations about their health. As early as the 1970s, when it was becoming apparent that basic health needs could only be met through the greater involvement of people themselves (Daley, 2006), successive international health agreements emphasized education as a key strategy for health development (Hancock & Minkler, 2002). Emphasis in practice was to be placed on shifting of control from health professionals to the community and to working with people in order to enable them to learn and to make decisions about their health needs and how best to address them. The overt ideological agenda was that the increased involvement of people in health decision
making would remedy inequities and achieve better and fairer distribution of health resources (Tones & Tilford, 2001). Influenced by Freire (1970), educational thinkers of the time popularized concepts of participation, empowerment, and dialogue, and active adult learning methods were promoted to help people examine the underlying issues behind the health problems they identified. Community participation and learner involvement became shared principles of health and adult education. Both fields were being developed in an effort to empower people to learn and to encompass individual and societal change.

Despite this early enthusiasm, there has been limited success in subsequent decades of working with people in participatory and emancipatory ways to reclaim health (Rifkin & Ratna, 2007). Although health is recognized to be affected indirectly through enhancing social competence, social support, and community debate (L. Hill & Ziegahn, 2010), the practice of educating adults about their health remains, with some exceptions (F. Hill, 2003, Laverack, 2007, Wallerstein, 2002), firmly rooted in providing health information and intervention strategies to encourage adults to work on individual lifestyle choices (Buchanan, 2006; Minkler & Wallerstein, 2008). Overall, little progress has been made in closing the growing gap in health status between different social and economic groups in society (Wilkinson, 2005). Globally, preventable chronic diseases are on the increase, comprising 60% of all deaths globally; 80% of these deaths occur in low- and middle-income countries, suggesting that an important underlying cause of all these deaths is poverty (World Health Organization, 2002).

Developments in using an adult education perspective in the area of health literacy, which focus on improving access to health information and the capacity to use it effectively, are encouraging (Chovenac & Foss, 2005; Schecter & Lynch, 2010). Health literacy enables citizens to navigate health facts and resources and to develop the personal and social skills in order to make positive health behavior changes, and increasingly in these processes the social constraints beyond the control of the individual (e.g., poverty) are being brought into focus (see Gillis & Sears, 2012). As such, adult health learning aimed at personal and broader social transformation, and involving dialogic and empowerment approaches, are more relevant than ever.

Transformative learning theory that focuses on broad-based change and deeper societal and cultural transformation (e.g., Freire, 1970) would seem a likely contributor to discussions about educating the community about health. Yet transformative learning theorists and researchers have not given a great deal of attention to this area of health. Those who have written about transformation and health include Courtenay, Merriam, Reeves, and Baumgartner (2000), who wrote about HIV/AIDS and transformative learning. Brendel (2009), Lyman (2009), and McAllister (2012) focus on the training of health professionals by using transformative learning theory to enact understandings of the complexity of health determinants and conditions that contribute to growing health inequalities.

Some people have written about health in transformational research, but many of them have looked at individual change that will lead to larger changes in the social and economic system that affect health (e.g., Baumgartner, 2002; Courtenay et al., 2000;
Moon, 2010; Ntseane, 2011). Few if any look at cases of actual transformation within group programs and within community settings or at how individuals experience transformation because of a health event, and fewer still have identified the aspects of these programs that facilitate transformation or serve as barriers to transformation. Considering that learning, informally and nonformally, in the community (see Foley, 1999) can be readily seen through the lens of transformation, stronger links need to be made in understanding the transformative learning of individuals in this context, and the potential for this learning to spur an interest in broader social transformation (Holst, 2002) to improve the overall health of individuals in communities. In this article, I present and discuss data from the perspective of both individual and societal transformation.

Background and Method

The participants in the CCHIM program were referred patients who either had experienced or were at high risk for cardiac, cerebral, or peripheral vascular disease. The program involved comprehensive risk screening before, during, and following participation in the program, including at 3 months and at 1 year following participation in the program. Participation involved groups of 15 to 20 participants attending sessions 2 full days a week for 12 weeks in their community. The program provided education related to heart health, nutrition, and physical activity; access to exercise programs; and pharmacotherapy, when needed. The interdisciplinary team facilitating the individual and group learning activities comprised a nurse, a cardiac nurse practitioner, a nutritionist, a physiotherapist, and a part-time health motivator.

Following approval of the study by the health authority (administering the CCHIM program) and the researcher’s university, all program participants at the five rural sites where the program had been delivered were invited to volunteer for the study. Eight to 10 participants at each site participated, for a total of 40 participants in the study. Group interviews were conducted in fall 2011. All groups informing the research had completed the program, although the length of time varied from 1 month to 2 years, thereby affording the researcher opportunities to discuss the challenges of sustaining learning and behavior change beyond the CCHIM program.

A case study methodology was used. As the goal of a case study is to “uncover the interplay of significant factors that are characteristic of a phenomenon” (Merriam & Simpson, 2000, p. 108), this case study explored factors and conditions affecting individual and group learning in the CCHIM program. The qualitative methods included five group interviews, which focused on individual and group learning within the CCHIM program. A thematic analysis was used to manually code data within and across sites in order to achieve “within-method triangulation” (Strauss & Corbin, 1990), and the trustworthiness of the broader themes and findings in the study.

Findings About Participant Learning

Through critical reflection on their experience in the CCHIM program, participants identified informal learning that was often transformative, enabling them to make
sense of their lives and to take action related to their health. This learning was linked with aspects of motivation, program design, and facilitation; participant learning in this article is discussed in relation to these aspects, beginning with individual motivation and learning in the program. Challenges to participation and learning are incorporated into the discussion of participant learning. Pseudonyms have been used to protect the identity of all participants in this study. The voices of adults shared in this article are representative of the wider group of program participants in the study; they all suffered with chronic cardiac disease and were engaged in the CCHIM program in order to learn to improve and protect their health.

A Transformational Event: Getting Started on Individual Change

Many of the adults in this study evidenced considerable transformation that came from their original health event, in this case cardiac events or severe warnings from physicians that they were in imminent danger. Fear provided their initial motivation to participate in the CCHIM program. A major heart event, or threat of one, provided a wake-up call and a “disorienting dilemma” (Mezirow, 2009) for them, challenging their taken-for-granted assumptions of good health. As a result, reclaiming health provided the key incentive for learning more about their health, although entering the program represented a “leap of faith” for many. They felt hesitant and anxious about their participation and performance in the program. This anxiety was mitigated to some extent by their shared experience of heart and other related chronic diseases. Identifying with the experience of others enables people to make meaning of their experience, which provides a motive to engage in learning (Kinsella, 2009). This potential for the program to offer a social space for sharing and meaning making provided an incentive for learning and participating in the program. As an environment for learning, the group aspect had strong appeal for Mae, a 38-year-old mother of three:

I was attracted because of the group aspect. I hadn’t realized much progress working on my own with my family doc . . . so while I knew I would learn from the health professionals . . . I had a sense that, in hearing others’ stories that were similar to mine, I would be able to make sense of why my life has ended up like this. After all, we were all in the same boat . . . and that was the most appealing part for me.

In naming her circumstance as “my life ended up like this,” Mae is pointing to the pivotal moment when she knew she had to change or die. For others, the turning point came in their individual appointments with the cardiac facilitators who ran the nonformal educational program. These appointments prior to the program were reported as significantly increasing participants’ motivation to learn. Through reflective dialogue with facilitators about their circumstances and readiness for change, participants reported beginning to be able to see themselves as more able to take action related to their health. John, a 63-year-old construction worker, talked about the transformational effect of that first appointment:
When they asked me I didn’t know what to say. I really had to think about what I would change and how I would change it . . . and if I was ready for that . . . Up until I had the heart attack I hadn’t really given any thought to my role in all of this . . . but they [facilitators] said it had to come from me . . . and they would support me . . . and that was a turning point . . . I began to own the problem and to think about myself differently . . . and to feel that I could change. Reorienting my thinking in this way really made for a great start for me in the program.

This owning the problem marked the moment that John was beginning to be transformed in his attitudes and his actions. Ownership in this way is integral to developing a capacity to engage with learning (Merriam, Caffarella, & Baumgartner, 2007) and prevention activities related to health (Merzel & D’Affittti, 2003). In transformative learning terms, ownership and a state of readiness are prerequisites for action leading to personal transformation (Taylor, 2009).

The accounts of John and others hint at transformative learning as they engaged with reflection on their readiness for change and on their previously held assumptions (Mezirow, 2009), as a basis for goal setting and action planning in the program. In these processes, they often reported realizing distorted assumptions about health and having an uncritical acceptance of their own health practices and beliefs and a naive reliance on health professionals. Bob, a 44-year-old lawyer, commented that in these processes of self-reflection his previously uncritical assumptions and frames of reference were challenged:

I resisted health information unless it suited me, and I thought the health system would be there for me if I needed it . . . like my fate was in someone else’s hands. Knowing that my coronary heart disease was preventable helped me realize that my own thinking was the problem, and that I needed to reorient myself.

Part of the transformation for John and Bob was realizing that their previous ways of coping and solving problems no longer worked; they were learning that they needed to incorporate new attitudes, beliefs, and behaviors into their perspective—in essence, to develop a new, transformed perspective (see Mezirow, 2009)—that would guide their action planning in the program and beyond. The CCHIM program supported this transformation in an ongoing dynamic of learning and reflection and in opportunities for participants to negotiate and renegotiate goals and to explore and test out new options—roles, relationships, skills, and competencies—for change. In this context—where experience was reflected on, assumptions and beliefs were questioned—they were more able to transform their habitual ways of knowing and to adopt new ways of knowing (see Taylor, 2009). In this case, Bob reports being able to make a shift from an uncritical to a more critical way of knowing and to adopt a future-oriented perspective in the program (which Courtenay et al., 2000, find is the essence of transformative learning).
I realized I was a very unquestioning person . . . and that was one of the first goals I set for myself in the program . . . to be more questioning of my own assumptions and not to take everything I hear at face value.

John and Bob's comments hint at being pushed into transformation in some sense. The threat to their lives caused then to reassess their beliefs and to change. Although many people do not have such life-threatening experiences, their stories point to the significant role of emotions in transformative learning. One's beliefs and expectations powerfully influence how one construes experience; they are embedded in one's values and identity and tend to become self-fulfilling prophecies. For the CCHIM participants, change was initially very threatening; they reported strong emotional responses to the need for change, including shame, anger, fear, and defensiveness, particularly in the early stages of the program. However, they said these strong emotional responses dissipated over time through dialogue and learning that enabled them to imagine how things could be otherwise and to establish a comfort level in the program. These encounters with others highlight emotional and spiritual dimensions of learning—dimensions that English and Tisdell (2010) say enable adults to learn alternate and varied ways of being and to acquire new insights about themselves.

**Transformation in Group and Community Settings**

Transformative learning as a collective process was also evident in the participant interviews. As Cranton (2006) points out, people may learn in community but still retain their individuality. A number of forms of community resonate in this study. Each group reflected the geographical and cultural community they inhabited, where the program was being offered. They stated a preference to learn in their geographical community with people they knew. In the CCHIM, they also functioned as a learning community, learning about their individual health in the context of the group.

As described by Mae earlier, the group structure and processes had strong appeal as an environment for learning for the CCHIM participants. They articulated the benefits of a group setting and processes, including that the knowledge and views of others was indispensable in helping them make sense of their own experience and learning in the program. In sharing their stories informally and in educational sessions, participants reported unexpected insights that enabled them to envision change, reinforcing Boud and Middleton's (2003) finding that informal interaction with peers is often a predominant way of learning. As they sought out beliefs and opinions that would prove truer or more justified to guide their future action, participants reported learning from collective knowledge created and owned by the group. Through personal reflection and group discussion of this collective knowledge, they reported being able to construct new individual meanings and understandings. Learning in this synergistic mode is recognized to enable adults to integrate divergent perspectives, increase self-awareness, and transform experience (Ziegahn & Ton, 2012).
As they built relationships and learned from and with each other, participants also reported increased overall levels of trust and diminishing power differentials, as group members and facilitators realized significant co-learning and progress toward shared goals. The participants noted that these factors of trust, friendship, and support (which Taylor, 2009, calls relational ways of knowing) enabled their learning to be more transformative. According to Taylor, a trusting environment for learning and promoting autonomy and collaboration are ideal conditions of discourse for fostering transformative learning. Bruce, a 42-year-old laborer, speaks to this balance of autonomy and collaboration in the CCHIM program and to the overall transformative potential of the group-learning environment:

They [facilitators] were giving us all sorts of individual attention but encouraged us to be a little more open and to share some things with the group. We were learning from them and each other, and that made you feel better about trying new things. They didn’t separate themselves from us like you might expect; they created a safe environment where we could process our own understandings.

Bruce was drawing attention to how shared learning and support in the group worked to bolster individual readiness for change, which is essential for action, an integral and indispensable component of transformative learning (Mezirow, 2009).

Overall, the participants identified the group structure and processes as helping them transform their thinking and adopt healthier lifestyle practices. Simultaneous monitoring of physical health outcomes, including weight loss and measured improvement in cardiovascular performance, blood pressure, and cholesterol levels (at 3 and 6 months and 1 year), helped reinforce learning and individual choices in the program. Most participants did achieve significantly improved health status while in the program and reported remaining highly committed to newly established health practices at 3 and 6 months and 1 year after completing the program. However, this level of motivation and commitment was more challenging for some once the program was over. Simone, a 62-year-old retired teacher, highlights the nature of this challenge, 1 year after completing the program:

It is a year now, and I do go to the diabetic clinic in [town name]. They give me resources, but the appointments are individual . . . the handouts are often hard to follow on my own and . . . you know . . . that is probably one of the biggest things for me . . . we are here and doing all this in a group . . . then you are on your own and it’s hard to keep at it . . . no reinforcement and, well there are some programs around here, there is the gym, but I just can’t go to the gym on my own.

Simone was pointing out here the observation that transformation for some was limited to the program time and that change for some was not permanent. She was also
hinting at the challenges of maintaining health gains without the social support of group members and the cardiac facilitators. Although the program was promoted as an opportunity for individuals to acquire the tools to sustain good health beyond the program, many participants reported worrying about this while in the program. Although they were encouraged to access local resources, particularly a “Your Way to Wellness” program—a peer-facilitated program that helped people living with chronic conditions learn to deal with everyday challenges—the program was only 6 weeks long and not available in every community. This reinforces that transformative learning is often not a onetime event but rather an ongoing journey of learning (see Moore, 2005) that must be supported over time, and the person must be validated in his or her experience. Although group support may nurture transformation, it also needs to be nurtured by the leaders of the group in the long run, beyond the life of the group—in this case through continued access to health information and a continuum of social supports.

The group structure also provided much needed social contact for people who experienced social isolation in their day-to-day lives, and those with no experience in group settings often reported learning how to participate and contribute in a group, as a health benefit of participation. Social support from within the group and from facilitators also enabled some participants to overcome barriers such as a lack of family support and feeling compelled to conform to normative family values. Susan, a 58-year-old retired nurse, commented on this tension in her life:

My husband can’t wait for our lives to “get back to normal” . . . but there is no going back for me . . . I feel so much better and have received so much support and encouragement here [program]. He feels threatened by all this learning and change in me . . . so will make it very difficult for me. I am worried about that, as I am sure others are in the program.

Susan’s comments illuminate the reality that despite significant personal learning and transformation, a range of barriers either internal or external to individuals can erode their motivation and commitment to change. In Susan’s case, external social pressure had the potential to discourage and inhibit her learning and transformation. In naming others as possibly experiencing the same pressure, she is hinting at the likelihood of commonly shared barriers to change. This suggests a rationale for nurturing, as a component of such programs, an individual’s capacity to anticipate and address personal and social barriers, both during and beyond such programs. The interconnected nature of group work provides an ideal environment for reflective dialogue where individuals can become aware of barriers to change, and develop sustainability strategies.

Facilitating Transformative Learning:
Educational Design as a Catalyst for Change

The adults in this study linked motivation with elements of program design and facilitation that supported transformational learning, which led to a continued sense
of confidence and control while in the program. For example, the group processes and the program duration (12 weeks) provided an opportunity for reinforcement of the educational content, highly relevant to the participants’ lives. Participants reported that key insights were realized and reinforced over time through experiential learning activities related to nutrition (e.g., food labeling, calorie counting, and portion size), physical activity and exercise, and medication management. Jane, a 24-year-old student talked about the transformative impact of this experiential learning approach:

The learning was hands-on and discovery based . . . we could see things for ourselves . . . like we looked at six different yogurt labels . . . we think yogurt is healthy but there was a huge difference in fat content . . . learning in this way had a bigger impact than if they just told us about it, and I felt more in control as a result.

Jane’s comments highlight that experiential learning that is active and achieved through interaction with others can be powerful and transformative for adults. In the CCHIM, these activities enabled Jane to experience learning more directly and holistically. In naming a sense of control, she was hinting that these learning activities were transformative; they evoked new understandings for future action (activities that Taylor, 2009, links with transformative learning). In addition to experiential learning opportunities, curriculum adaptations further increased access to the program. For example, adapting print materials or combining dissemination of print materials with verbal instruction, visual aids, and discussion mitigated barriers of low literacy. These program design features helped participants stay motivated and focused on their goals and action plans in the program.

The facilitation style of the cardiac team, characterized as balancing group and timely individual instruction, an emphasis on progressive individual improvement and self-paced learning also increased access and reinforced informal learning and transformation in the program. The capacity of facilitators to anticipate culturally appropriate learning strategies was also seen as reinforcing learning and transformation. Audrey, a 63-year-old gardener, describes how the familiarity of the facilitators with the local context and culture enhanced learning:

They [facilitators] helped us think about how we could apply what we were learning in the context of our communities. They know how things are around here. They helped us figure out a way forward, like using the hiking trail, and talking to the store manager about better produce.

Audrey was hinting that the facilitators helped the participants think about health in the context of their day-to-day lives and that this helped them develop realistic strategies grounded in their lived experience. According to Taylor (1994, 2010), inclusive learning strategies that are likely to be transformative (a) acknowledge the influence of what adults bring to their learning experiences (context, culture) and (b) provide access to knowledge and experiences that enable them to bring balance back into their lives.
Connecting From the Individual to the Collective in Transformative Learning

In the CCHIM program, participants learned a great deal about themselves, their health, and how to transform their health practices to improve their overall individual health. Reinforcing that social transformation begins with individual transformations (Mezirow, 2009), many participants reported also having insights related to the broader social, political, and economic roots of poor health. This was particularly true for participants who had been out of the program for 6 months to a year, who reported that learning in the program resonated with them long after the program. As they reflected on their individual learning and consequent changes in their health, they reported looking beyond themselves to the world around them and experiencing incrementally new insights about poverty and food insecurity, seniors and children’s health, and environmental concerns. For example, in learning to read food labels, Sienna, a 57-year-old bookkeeper, was beginning to have insights about the potential of a more local food supply:

Now that I read and interpret labels I feel more able to make choices. For example by looking at the salt content I know what foods I should not have and naturally now I have a sense that fresh local food is the way of the future.

And the change was not limited to personal concerns only. For example, Mae expresses some concern over the potential for her family to model her previous personal health practices:

I see that my children and their children’s lives have been taken over by machines; they have no time to eat well or to go for a walk. All that convenience stuff and no exercise . . . I can see that they are heading down the same road I was on.

Some participants also reported insights on broader societal issues and conditions that impacted health. For example, Janine a 60-year-old retired factory worker, found herself wondering about the cost of being healthy, and the impact on particular populations:

Why is fresh food so expensive? Why is fish from Japan cheaper than what is caught locally? This makes eating well more of a challenge for low-income people like me.

These comments suggest that the educational processes of the CCHIM stimulated critical thinking and transformative changes in how participants understood the world around them. For some, this extended to understanding the need for healthy public policy to safeguard community health and in some cases to envision themselves as agents of change in reclaiming community health. For example Annette, a grandmother
of six, was considering a role for herself in broader social change to safeguard the health of her grandchildren:

I am not an activist, but now that I have my own life under control, I can help others see the need to take some action to change our patterns of living ... food and physical activity ... but also the environment ... cancer rates are so high here ... not much of a legacy for our grandchildren.

Social reform of this kind has long been a goal of adult education (see Cranton & Wright, 2008), and transformative education extends its focus beyond individual transformation to helping learners learn how to make a difference in the world. This capacity for individuals to reflect critically on real-life circumstances and to envision change that improves the health of communities is a goal of empowerment models of health development (Rifkin & Ratna, 2007) and a central rationale for community-based approaches to health education (Easterling, Gallagher, & Lodwick, 2003). According to Tett (2001), the benefits to the individuals taking action to ensure community voices are heard and health resources redistributed extend to include being empowering and having direct health benefits.

**Significance and Implications for Transformative Learning and Health**

The exploration of informal learning in this case study reveals conditions recognized to support adult and transformative learning. As this article highlights, the program structure, learning processes, and facilitation style in the CCHIM incorporated best practices in adult education. For example, the program was described as learner centered (Weimer, 2002); it acknowledged the experience and social context (Hansman, 2001) of the participants and provided opportunities for them to learn from their experience (Merriam et al., 2007). Responsive facilitators, focusing on the learning processes involved, enabled participants to take the initiative, with or without the help of others, in diagnosing their learning needs, formulating learning goals, identifying resources (including cultural), and evaluating learning outcomes (Merriam et al., 2007). According to L. Hill (2011), programs that are designed with the needs of adult learners in mind can be more effective in helping them see the necessity of behavioral or lifestyle change.

In this nonformal setting, participants had opportunities to engage with variety of forms of learning (i.e., informal, nonformal, problem based), which acknowledged their unique learning preferences, in response to illness (Kinsella, 2009). The design of the program provided many opportunities for hands-on learning through practical and experiential group activities. Participants also had opportunities to engage with independent and self-directed learning. The opportunity to engage with various types of learning is recognized in order to enable individuals living with chronic disease to develop relevant and manageable coping strategies (Baumgartner, 2011). In this case,
facilitators elicited problems from program participants, both individually and collectively, and supported them in their search for practical answers.

Emotion is integral to living with a chronic disease (Baumgartner, 2011). In addition to the information learned, emotional and social support was vital to the processes of learning and transformation in the CCHIM. Supportive relationships between the facilitators and program participants created an incentive for participation (e.g., see Baumgartner, 2011) and a favorable environment for information and experience sharing. Support located in the instruction and facilitation (i.e., experiential learning and group activities) also provided opportunities for connected knowing or understanding through empathy (see Belenky, Clinchy, Goldberger, & Tarule, 1986). This resulted in increased confidence and levels of personal and collective efficacy (see Bandura, 2000) among group members who shared common concerns and experiences. Collective efficacy is the belief among group or community members that they have the capacity to create change (Wallerstein, 2002). Some participants felt more empowered, felt connected to others, and experienced a change in worldview as a result of being part of the group. In a health context, social support is recognized to play a key role in a decision to change health related behaviors (e.g., see Baumgartner, 2011) and is often cited as a determinant of health (Uchino, 2006).

Processes enabling learning outcomes to be transformative were those that Cranton (2006) and Mezirow (2009) suggest lead to transformation. At an individual level, illness was an activating event that exposed the limitations of the existing knowledge of most participants. In discussing their readiness for change, they were exposed to viewpoints discrepant from their own and provided with opportunities for self-examination, where they could assess previous assumptions and expectations, and those of others. Through critical discourse, with the facilitators and other participants, individuals were able to envision alternative ideas and behaviors and to test them out. According to Cranton (2006), when these processes occur, adults are more likely to revise their underlying assumptions, adopt new points of view, and apply these new viewpoints to their daily lives. This outcome is evidenced in the degree to which CCHIM participants reported learning that enabled them to make changes in their day-to-day health practices during and following the program. According to Mezirow (2009), at a collective level, it is this transformation within a group context that gives individuals more courage to initiate social change within their communities. This study clearly shows that once some of the individuals were confronted with illness, their attention became broader and their levels of knowledge of social conditions affecting health were enhanced.

There is a tension in this transformative learning study that must be recognized. Although the learning that is reported is mainly individual learning, it operates within the larger structure of a health system that itself needs to be transformed. The transformative learning of individuals is indeed important and does help researchers understand the role of learning in the community and how it can be facilitated. Although some of the participants saw this experience as a route to deeper social change, for some the change remained rooted in the individual experience. Yet the larger project
of structure transformation, such as advocated by Freire (1970), and implicit in the social determinants of health philosophy, is hinted at here. Adult educators may indeed have a role in helping move this individual focus to the collective.

This case study provides insights into the role and processes of adult learning, especially transformative learning, in community-based health programs, an area recognized as theoretically and practically underexplored. The study reveals the importance of monitoring learning beyond such programs to determine if transformative learning within such programs dissipates over time. In addition, the study provides insights into how informal and transformative learning can be supported in this context. Those interested in transformative learning as a field of study and practice can find implications in this study for working with those in health-related areas, especially in community settings. They will see how emotion plays a role in transformative learning and how the facilitator has a key role to play in supporting the learning of participants, in both the short term and the longer term. Transformative learning theorists can see how the individual and the collective interests can be incorporated into program planning for the community. Given the trend toward an aging population and the increase in health professionals with an interest in community-based learning, studies in the area of community health are much needed. Case studies, such as this one, that focus on the learning that is occurring in and among groups can provide rich detail on the role of emotions in transformative learning.

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