EMBRACING AND EXTENDING THE MARGINS OF ADULT EDUCATION:
EXPERIENCES OF INTERDISCIPLINARY COLLABORATION

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Abstract

Adult educators, working in non-traditional interdisciplinary settings, sit at the confluence of where the margins of several disciplines meet to exchange ideas on how to advance theory and practice to facilitate adult learning. This paper uses two case studies of how adult educators work in interdisciplinary non-traditional adult education organizational settings—a state-level family literacy initiative and an interdisciplinary online adult patient education research and development program—to improve programs that facilitate adult learning. The paper concludes with a discussion of barriers to and strategies for integrating adult education principles into mainstream programs.

Introduction

As adult educators, we increasingly risk and resist being placed at the margins of academic and other organizations. Margins, by most common definitions, are power- and resource-poor positions relegated to supporting rather than to setting organizational or societal missions. The power to marginalize often comes with funding that rewards the rigors of scientific method with their clean research designs and quantifiable outcomes and minimizes the qualitative, process-oriented questions that drive much of the educational process. According to this common definition, those with greater power place us at the margins *against* our wishes. Certainly, no rational field of study or practice would choose to occupy organizational margins. Or would it? We argue that depending on how you define the margins, the answer rather lies somewhere between "no" and "yes." Using the common narrow definition, certainly, adult educators do not choose to occupy the margins accompanied by diminished decision-making and financial power. However, we must also acknowledge that our choices do contribute to our marginal status. Many adult educators choose to work with "disenfranchised" rather than privileged audiences; have a social change mission that empowers people by grounding them in their life and cultural experience and encourages them to reflect on power relations and change social institutions (rather than changing to fit in); and we favor qualitative and critical (rather than quantitative outcome) teaching and research methods. Thus, adult education as a field of study and practice, in part, chooses to occupy the margins.

On the other hand, margins can be powerful observation posts from which to understand organizations (and social phenomena) from insider and outsider perspectives—and thus, to influence social and organizational missions. In fact, more innovation and change occurs at the ideological or power margins than at the center. Of course, deriving strength from the margins relies on building collaborative relationships that span the disciplinary or ideological boundaries that often cloud creative problem solving and on framing the factors that marginalize us as assets. And, indeed person-focused social change and the multiple perspectives of critical/qualitative methods are assets! Increasingly adult educators work outside traditional academic departments and community settings and in interdisciplinary collaborations that advance adult learning in challenging life events.

Field Notes: Examples of Interorganizational and Interdisciplinary Collaboration

This paper provides two examples from a larger project (in process) that explores how adult educators work in several settings (e.g., community organizing, inter-religious dialog) to embrace and expand the margins through inter-organizational and interdisciplinary collaboration. The idea for this project was hatched over several luncheon meetings. We realized that, like many of our colleagues, we worked as sole adult educators in interdisciplinary organizations at the crossroads of several margins to facilitate adult learning amidst challenging adult life tasks. Moreover, we recognized that while we had a lot to offer, working in collaboration enhanced our understanding of how adults learn and how to facilitate such learning – as innovative thinkers from several

disciplinary perspectives bring a range of experience and methods to understand and address the challenges at hand. In the first example, Glowaki-Dudka describes how adult education principles are integrated into a state-level initiative to address family literacy through interorganizational and interdisciplinary collaborations. Next, Wise describes how an innovative academic research center uses interdisciplinary collaboration to develop online patient education programs for adults facing health crises. She will focus on the convergence and divergence of learning theories and perspectives across the disciplines. We conclude with suggested strategies for how adult educators can collaborate in interdisciplinary social change programs.

A Holistic Approach to Family Literacy through Interdisciplinary Collaboration

Research shows that adults with low-literacy often live in poverty and their children tend to perform at lower levels than their middle class counterparts (Children's Defense Fund, 1995). This, can lead to numerous social problems for families when their children develop into adolescents and young adults, including dropouts, unemployment, and a continuation in the cycle of poverty (U.S. Department of Education, 1999, Digest of Education Statistics, 1998). Typically, individuals' needs are addressed in a segmented manner. Schools teach children. Colleges teach young adults. Social programs serve social needs. Adult educators teach adult basic skills. And welfare-to-work instructors train workers. Increasingly, the family is viewed as a more capable unit to address the myriad of problems stemming from low-literacy when proper social supports are in place (NCFL, 1989, 1997). Family literacy programs combine adult basic education, early childhood education, and social services in a centralized holistic manner to meet the needs of the family without requiring that they seek out services.

A federally funded collaborative program was begun in 2000, which granted funds to states to improve family literacy. Michelle Glowacki-Dudka, an adult educator, coordinated the Wisconsin Family Literacy Initiative State program. Consultants at the Wisconsin Technical College Board and the State Department of Public Instruction designed the grant to bridge a university with state-level educational agencies to provide seed money for local programs to make government systems more family-centered. The collaboration was established to raise public awareness, train a variety of educators and family specialists, and work with unlikely partners at the state level to gain support for "families learning together". It includes groups serving children through schools and child protection groups (Wisconsin Early Childhood Collaboration Project and Head Start) and groups serving adults through the Wisconsin Technical College System and the Governor's Office for Literacy and Lifelong Learning. While collaborators from child-focused services tended to focus on children's needs, adult educators expanded the dialog to consider that parents and adult family members in child-rearing roles must be supported through specific program features. The State allocates millions of dollars to childhood education and much less to adult education in underserved communities (Wisconsin State Budget, 2001). Moreover, while the education of children and adults go hand in hand in promoting family literacy, child and adult education organizations do not often work together. The Initiative was intended to improve this situation through awareness, dialogue, negotiation, and collaboration.

To that end, the Initiative established four levels of collaboration– the management team, local program coordinators, the consortium, and the support team.

The management team (chaired by Glowacki-Dudka) was the core decision-making body. It consisted of representatives from each collaborating agency who served as boundary spanners between the Initiative and their agencies. In addition to defining goals and processes, the management team provides guidance and tools to local program coordinators to assure facilitated success and assure continued funding. Difficulties arose when representatives did not understand their liaison role between the Initiative and their agencies and communication did not travel back and forth from each organization. Embracing the role of margins and boundary spanning must be understood and well established throughout the collaboration. Otherwise, people do not feel included in the activities and do not share ideas.

Local program coordinators regularly document their progress and participate in professional development meetings, research projects, and the evaluation system to report progress. The Initiative also supports the work at the local level by modeling and encouraging collaboration among local providers of services to families. Through the consortium and support team at the state level, the Initiative raises awareness among service providers directly to families in the state, gathers support from state legislators by communicating the importance of integrated and collaborative services, and establishes relationships with colleges and universities that prepare teachers to deal with issues of families in their future work. In order to achieve these goals, a large consortium of state agencies, providers of family services, and legislators was assembled. This group is made of people who specialize in their own fields, yet understand the value of reaching across the boundaries of their job descriptions and state roles to work with complementary peers in other agencies or organizations.

Following the lead of adult educators, consortium members also bridge agencies serving adults with those serving children to design integrated family literacy programs. Notably, participating in this collaborative project placed each consortium member at the margins of his or her agency's mission. However, such collaboration and interagency communication facilitated more effective family learning and used the State's sparse resources more effectively by not duplicating work (with a more parochial perspective) in multiple agencies.

Barriers to adult educators' collaboration and affecting change at state-level integrated family literacy programs include:
- Bureaucratic structures that block communication between agencies
- Predominant child-only philosophy that does not value parents contribution to learning
- Limited time, staff, and resources to meet an overwhelming workload
- Unclear roles about who should be bridging the organizations – whose job is it anyway?
- Budget crises in the state that puts everything on hold
- Diminishing momentum and support for change

In sum, the Wisconsin Family Literacy Initiative is a good example of how adult educators can embrace the margins. That is, by working outside traditional academic departments or community settings with state agencies (a non-traditional setting). Adult educators are well suited for this role as are tuned into learners' needs, understand how individual learners' needs fit into their family and societal contexts, and can advocate for learners' services while also planning for future programs.

Interdisciplinary Collaboration in Online Adult Health Education Research

Background. Health crises are universal events in the adult lifespan. While such crises pose an opportunity for profound learning in technical, sociopolitical, behavioral, and existential realms, adult educators have not traditionally provided or evaluated patient education. The reasons are manifold–but foremost is that nursing, medicine, psychology, and the allied health fields have primary and licensed authority to educate adult patients. Traditional patient education applies rational, behavioral, and deficit learning models to help individuals achieve measurable outcomes based on educator–rather than learner-defined goals (Wise, 2001). For instance, cardiac rehabilitation and other chronic disease education program focus more on the behavioral (such as exercise training or dietary tips) and mechanical (learning to take prescribed medications) aspects of managing illness (AHCPR, 1995) than on the emotional, social and spiritual aspects of learning to be whole in the face of living with limitations (Ornish 1998). Increasingly, however, patient educators recognize that such approaches do not yield pre-set bio-behavioral outcomes for the majority of patients–especially patients from non-Western or low socioeconomic groups, or patients who have unresolved emotional and relationship issues (Daaleman & Vandecreek, 2000). This—with the recent confluence of managed care cost containment, patient advocacy, public fascination with complementary (mind-body) medicine, and web-based health education—has resulted in generous funding for interdisciplinary research to develop and evaluate the next-generation of patient education programs. Such research in several disciplines addresses how people from a range of cultures construct the meaning of health and illness and life and death (Byock, 1997), the

locus of decision making, doctor/patient dialogue, the individual in social context, the role of narrative learning (Pennebaker & Segal, 1999), the relationship between reflection and action (Prochaska & diClementi, 1986); how to fully use technology for cognitive and social learning; and inequitable access to healthcare and the Internet (Eng & Gustafson, 1999). Notably, these questions and emerging theories, generated at the innovative and often controversial margins of several health-related disciplines, converge more than they diverge with adult and distance education theories and practice. These theories have been operationalized and articulated by an interdisciplinary academic research center that develops and evaluates web-based patient education programs. Notably, Meg Wise write from her experience as a developer and researcher with the CHESS project for over a decade–during which time she studied adult education to understand adult learning processes in the face of health crises.

The Comprehensive Health Enhancement Support System (CHESS). Since the early 1990s, the CHESS interdisciplinary research team has developed, evaluated, and continuously improved computer-based patient education programs to empower people living with a range of health-related challenges (e.g., breast cancer, heart disease, asthma). These programs deliver anytime, confidential access to information, social support, and interactive decision-making and skill-building activities to help people facing health crises to become full partners in treatment decisions and self care (Gustafson, et al., 1993; Hawkins et al., 1997). Its guiding principles are to demystify the technical aspects of the illness, explain the treatment process and how to negotiate the healthcare system, and to normalize often ignored social and emotional issues through information, and peer and expert support. The core interdisciplinary team (including industrial engineering, health communication, education, psychology, and management) collaborates with clinical experts in specific illnesses (e.g., cardiologists, oncologists, nurses, dietitians, exercise physiologists, stress management experts, etc.). The most valued collaborators, however, are the people living the illness experience (including spouse or family), who instruct the team about their concerns, and information and support needs at different phases of the illness experience (e.g., diagnosis, treatment, getting back to normal life patterns, anniversaries, addressing family concerns, etc.). Program development is driven primarily by people's needs (as identified through focus groups, in-depth interviews, literature reviews, and surveys), motivated by their struggles, and inspired by their resilience and what people have to teach us. Evaluation is primarily driven by quantitative outcomes (quality of life, satisfaction with health decisions)

Convergence of CHESS with adult education theories. From a learning theory perspective, CHESS is informed by health behavior change theories, such as self-efficacy (confidence in one's ability to change is the biggest predictor of change), the health belief model (people act based on their perceived illness threat relative to perceived value of changing), and the transtheoretical model (change is an interactive process between reflection and action) (Hawkins et al., 1997). Each of these theories designates a range of cognitive and social activities, such as self-monitoring, expert information and coaching, role models, social support, and reflective trial and error. These theories are driven by the underlying assumptions that a diagnosis of a serious illness (disorienting dilemma) provides the initial motivation to actively learn about the technical and psychosocial aspects of their illness and thereby align one's life with reframed priorities (perspective transformation). To that end, CHESS provides salient information in a range of formats (e.g., FAQs, research articles, personal stories, and consumers guides to health and social services), on-line peer support (where people construct their knowledge through shared experience), and interactive guided planning tools (self-assessment, reframing priorities, and guided journaling).

Early versions assumed a completely self-directed learner – who took complete responsibility for whether or when to logon or to participate in on-line discussions, and for finding salient materials in CHESS. However, later versions include instructional features that provide opportunities for learners to assess their status, frame relevant learning goals for the session, and follow CHESS' links to salient information or learning activities to meet those goals. Through continuous evaluation, CHESS is now developing even more explicit learner contracts that require regular "class attendance" to report specific health status in order to facilitate communication with the clinician or ton guide the learner toward a longer-term health learning goal. CHESS is also

developing more opportunities for the patients' partner or family to participate in separate or joint learning activities. Moreover, well aware of the digital divide (Gustafson, 2000), CHESS provides Internet computers, training, and technical support to people who do not have home computers in funded evaluation studies, and expends intensive efforts to include non-white and underserved people in formative and evaluative research. CHESS' pedagogical approaches converge with a range of humanistic, rational, and social/cognitive adult learning theories – such as self-directed, transformative, self-efficacy, and double-loop (see Merriam & Caffarella, 1999). Notably, these are the mainstream adult learning theories—helping *individuals (or immediate family)* to identify their deficits and providing tools to develop proficiency in the face of challenge.

Adult education theories that could stretch online health education programming. CHESS does not incorporate, at this time, adult education's more provocative critical and non-rational learning theories. CHESS certainly empowers people to take individual actions and responsibility for their health- and self-care (e.g., being a self-advocate, changing diet, improving communication skills). However, it does not facilitate deep analysis of and organizing to change the social or environmental conditions that affect illness – such as, the role of local industrial polluters and substandard housing landlords in asthma exacerbations; nor the role of community planning that discourages walking or bike riding for commuting or shopping or fast food corporations that target poor neighborhoods in the increasing prevalence of heart disease or other obesity-related illnesses; nor the role of low-wage jobs in family and personal stress; nor how national healthcare financing policy produce an asymmetry of healthcare quality that often forces choices between food or medicines for low-income people. The barriers to changing these society-level contributors to illness are immense–dialog, however, is never closed.   Integrating non-rational and non-linear (right brained) learning pathways to help people make deeper meaning of their illness may be easier. Although CHESS presents information in linear, rational and textual (left brain) modes, it *already* provides a forum for the right brain through its online peer discussion groups, personal stories (in text and video), and guided journaling projects. The team is considering using music, video, games, art, and poetry to convey information, deepen understanding, and to facilitate personal change.

In sum. CHESS, developed by innovative interdisciplinary team, is an evolving learner-focused program that integrates adult education's mainstream core values, theories, and practice: open-minded, creative thinking and practical problem solving, building collaboration through support respect for diversity of ideas, mentoring each other, seeking to understand and incorporate multiple learning pathways.

Discussion

These two examples of adult educators working in collaborative settings lay out a range of issues about how adult educators can learn from other disciplines and raise critical questions to facilitate learning for adults in non-traditional settings and domains of adult learning. For instance, the Family Literacy Initiative allowed the adult educator to better understand children's issues from children's services providers' perspective while advocating for the parents' educational needs. Likewise, CHESS allowed the adult educator to understand learning issues from the perspectives of patients, clinicians, and a range of communication and learning experts—an opportunity that adult educators rarely have. Both projects are facilitated (and perhaps limited) by federal agencies that sponsor and fund program development and evaluation – and this demands that adult educators continue to hold broad and inclusive epistemologies as they include the qualitative sensibilities with quantitative outcome evaluation.

We conclude with three enduring lessons we have learned in interdisciplinary and interorganizational collaboration:

- First, several disciplines overlap with adult education in mission, theory, collaboration style, and assumptions about life long learning. Thus, adult educators don't have a corner on any particular set of ideas. We do have a well-articulated body of theory and practice to share with to our collaborating colleagues.

- Second, margins seeking to change traditional ways of serving adults exist at most disciplines. We need to work with these change agents. The potential for growth and change is at the borders of a number of disciplines.

- Finally, we must consider that parochial epistemologies that look only out of the constructivist and critical eye lack the stereoscopic vision needed to gain funding grants, which enable us to influence adult learning in important life events (e.g., health crises and family literacy). We must open the other eye and understand how quantitative outcomes and generalizability work hand in hand with qualitative process questions in particular contexts.

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