What a University Students Learn in an Intergenerational, Holistic, Service Learning Health Promotion Program

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Abstract

This article describes an intergenerational, holistic, health promotion and rehabilitation, service learning, academic course. It also serves as an introduction to articles by five participating students. The Adult Health & Development Program trains students to apply gerontological health theory as they work on an individual basis with institutionalized or non-institutionalized older adults. Implications for health professionals include training to meet the health needs of the increasing older population, and our unique potential to reduce violence, and otherwise improve human relationships.

Introduction

Phrases such as *service learning*, *intergenerational programs*, *community service* and *outreach*, and *peer learning* are now considered academically correct. For example, there are more than 600 citations on *intergenerational programs* in ERIC alone, and the topic is popular at health, gerontology and other educational and scientific conferences.

It is not the purpose of this article to examine the reasons for this growing interest. Perhaps it is partially explained by the desire of many in the academic profession to apply their knowledge to addressing social problems and issues (Boyer, Altbach & Whitelaw, 1994). The late Ernest Boyer and his colleagues wrote in their report sponsored by the *Carnegie Foundation for the Advancement of Teaching*:

> Finally there is service. Today professors all around the world support the idea of wider engagement. Overwhelmingly, they feel a professional obligation to apply their knowledge to the problems of society, building a bridge between theory and practice (Boyer et al., 1994, pp. 22).

Implied was the notion that the academician would also gain in the exchange. Not only would he or she have opportunity to test hypotheses, and apply and modify models and theories for the social good, but would also learn and grow in the exchange with the community.

It follows that students and their professors, and the community could benefit from a similar social contract, that is, collaboration to achieve a common good. The purpose of this series of articles is to describe one such collaborative effort from the participating students' view. The venue is the 26-year-old intergenerational, service learning, holistic, health promotion and rehabilitation program, the *Adult Health & Development Program at the University of Maryland (AHDP).*

This article serves as an introduction to five articles written by students who participated in the *AHDP*. Their insights and analyses provide a richer and different documentation of their experience in the *AHDP* than could be provided solely by quantitative analysis. Grounded Theory teaches us that any experience is subject to the meaning given it by the actor (for discussion of the symbolic interactionist approach see Timasheff, 1976; Back, 1976; Marshall, 1980; & Leming, 1990). Thus, the student's perception and meaning given an academic experience is seen as vital in any evaluation of that experience.

What is the AHDP?

The *AHDP* and its spread to other colleges and universities (called *The National Network for Intergenerational Health — NNIH*) has been described in the literature (Leviton, 1989; Leviton, 1991a; Leviton, 1992; Leviton, Redman, Cordova & Hin, 1995; Leviton & Santa Maria, 1979), and on its home page at:

http://www.inform.umail.umd.edu/HLTH/faculty/dleviton.

Essentially, the *AHDP* matches trained students and volunteers (called **staffers**) diverse in terms of academic major, age, economic status, and race and ethnic background to work on a one-to-one basis with older institutionalized and non-institutionalized adults (called **members**) for nine Saturdays each semester. About 50-90 members, 50-90 staffers, and 20 senior staffers are involved in this health education course, and medical school elective.

The staffer helps his or her member get into a health and well-being pattern by participating in the physical, social, and health education activities of the

AHDP. Staffers are supervised and nurtured by 15-20 **senior staffers**. Each senior staffer and his or her associate is responsible for 7-10 staffers. The senior staff, whose average length of service in the *AHDP* is six years (one has been involved for 16 years), plays a significant role in all aspects of the *AHDP* including training, evaluation, grading, and its modification.

The nature of physical and social activities, and health education, where staffers and members learn together, in an intergenerational context is nonthreatening and enjoyable. Thus, members and staffers return year after year to the *AHDP*. The average length of involvement of members is also six years with some having been involved for more than 16 years.

Goals of the AHDP/NNIH

The goals of all *AHDPs* are to:

1. Positively affect the health, sense of well-being, physical activity, and health knowledge status of the older adult.
2. Allow the student and other staffers to learn of aging, old age, history and different cultures in our particular environment.
3. Have the *AHDP* serve as a catalyst integrating various age, ethnic groups, the University, and community to work toward the common purpose of goals numbers one and two.
4. Contribute to world peace and global cooperation by integrating a diverse group of individuals into a mutually supportive and purposeful group.

Keys to the AHDP/NNIH

The five keys to the uniqueness of all *AHDPs* are:

1. The integration of physical and social activities, and health education as a means to improving physical and social activity status, self-concept, subjective and objective health and well-being, health knowledge, and some control over one's own health.
2. The one-to-one pairing of the staffer and members over a sustained time period each semester. A special bond develops between staffer and member. While the staffer is helpful to the member, the member, in turn, is helpful to the staffer. For example, all members are a source of living history. Nearly all lived through World War II (see Craig's article). Often the member can often help the younger staffer cope with problems. Staffers also learn of diversity with special reference to health and disability (see Guenther's, Frank's, and Staten's papers), and race and ethnic roots (see Frank, and Welch).
3. The systematic education, training, and supervision of staffers by senior staff and faculty.
4. Honoring the wishes and expressed needs of the member rather than "telling" him or her what is "best."
5. The loyalty of staff and members to the *AHDP*, and vice versa.

Members

Using the spring semester l998 semester as a guide, there were approximately 80 older adult members participating in the *AHDP*. Their average age was approximately 65 years, range = 48 to 94 years. Thirteen members were domiciled in a VA nursing home; 10 were Hispanic elderly from the community (matched with Spanish-speaking staffers) 12 were people with developmental disabilities, and 45, the largest number, were non-Hispanic members from the community. About 52% represent ethnic or racial minority groups. Members are diverse in age, SES, health status, and race and ethnic background.

Staffers

Staffers are trained to serve as **friendly coaches** to their members. Their task is to serve as change agents helping their members get into a health and well-being groove depending upon the members' motivation for attending the *AHDP*. However, the member does what he or she wishes to do. Coercion and patronizing are not tolerated.

Staffers, too, are diverse in terms of academic major, SES, and race and ethnic background. Similar to our members, more than 50% represent ethnic or racial minority groups. Many staffers are motivated to enter professions involving health aspects of gerontology/geriatrics, or become advocates for older adults in one way or another. About 60% of the staffers and members are female. The diversity of staff and members is intentional as it contributes to the notion that young and old can learn much from one another. Some staffers are high school students. The youngest staffer was 14 years of age. More than 95% of staffers who have applied to medical, other professional schools, or graduate school have been accepted.

Schedule

The *AHDP* meets for 11 Saturdays each semester from 8:00 a.m. to noon. The senior staff consisting of Associate Directors (two), Group Leaders and

Associate Group Leaders, Group Advocates, Specialists, and *AHDP* consultants meet before, during, and after the *AHDP* begins and ends each semester, and from 8-8:30 each Saturday morning. Meetings focus on the improvement of leadership skills, problem solving, training of staffers, ways of improving the *AHDP*, etc.

Staff training runs from 8:30 - 9:30 a.m. and, again, at the end of the day, from noon to 1:00 p.m.. As the senior staff (group leaders, associate directors, and specialists) gain in experience they increasingly conduct training. Training involves both the dissemination of gerontological health theory and data knowledge, their application in working with members, and analysis of the process (the staffers' articles indicate how this is done).

Staffers are trained to follow the *AHDP's* **ACAEM** paradigm that is referred to in all of staffers' articles. It provides the basic structure for the staffer' interaction with his or her member.

Each novice and experienced staffer is supervised by a Group Leader (GL) and an Associate Group Leader (AGL). GLs, AGLs, the Associate Directors, Specialists (exercise, aquatics, etc.), and Advocates (for the Foreign Born, Developmentally Disabled, and Institutionalized Groups) make up the **senior staff**. The GLs and AGLs provide feedback and supervision, both written and verbal, during each of the nine sessions of the *AHDP*. Staffers learn that they will do well if they are motivated and open to the constructive criticism of their GL and AGL.

At 9:30 the members arrive and are met by their staffers. 9:30 to 11:00 is the activity hour where the member-staff dyad engage in activities including walking, bowling, swimming, jogging, square dancing, aerobics, Yoga, singing, t'ai chi, games, sports, resistance exercise, and/or individualized activities.

Health Education

Since **preventive intervention** is an important aspect of the *AHDP* a health education hour is conducted from 11:00 to noon. During this time topics such as coping with stress, physical fitness, prevention of Osteoporosis, grief and bereavement, the intelligent use of medications, medical problems, etc. are discussed in both Spanish and English led by experts in their field.

At the end of the day staffers accompany their members to their transportation while recapitulating the day's events, progress made, and plans for the next week. Staffers contact their members during the week by telephone or visit. Staffers then return to group meetings led by their GLs and AGLs.

Conceptual Framework

The practices and techniques associated with the *AHDP* are derived from an eclectic theoretical framework that Fries "Compression of Morbidity Hypothesis"(Fries, 1984; Fries, 1997); Activity Theory (Kart, Metress & Metress, 1988; Paffenbarger et al., 1993; Shepard & Montelpare, 1988; Surgeon General, 1996; U.S. Department of Health & Human Services, 1992; U.S. Public Health Service, 1992; Walker, 1989); sociologically-grounded theories like Symbolic Interaction Theory; our adaptation of the Health Belief Model (Rosenstock, 1990); Reference Group theory (Hovland, Janis & Kelley, 1953; Janis, 1982a; Janis, 1982b); and the Horrendous Death, Health and Well-Being Concept (Leviton, 1991a; Leviton, 1991b; Leviton, 1995a; Leviton, 1995b).

The National Network for Intergenerational Health (NNIH)

The NNIH is the proliferation of *AHDPs* throughout the United States. As a result of grants from the U.S. Department of Education, and the Disabled American Veterans Charitable Trust, programs were developed at Arizona State University, Bloomsburg State University, the University of Delaware, Florida A & M, Nicholls State University, Northern Virginia Community College, University of California at Long Beach, Coppin State University, University of South Alabama, and Claflin College. Chesapeake College (Wye, MD), and the University of the District of Columbia developed their programs in the 1980s before we received our training grants.

A three-year grant from the John A. Hartford Foundation allows for the development of 16 additional sites during 1997-2000. Universities that sent potential directors for training in March 1998 included Kennesaw State University (GA), Virginia Tech, Towson State University (MD), Montgomery Junior College (MD), Springfield College (MA), Lynchburg College (VA), University of Texas Medical School, and Tuskegee University.

Scheduled to be included during the second wave of training in the fall 1998 are NOVA (FL), San Francisco Community College, Purdue University (IN), Butler University (IN), Marquette University (WI), SUNY at Oswego (NY), James Madison University

(VA), Pittsburgh State University (KS), Adelphi University and others. If interested participating in the grant, that is, developing an *AHDP* on your campus, please contact me by email at DL16@UMAIL.UMD.EDU.

The Staffers' Final Analysis Papers

As part of the requirement for the *AHDP*, staffers are required to write a Final Analysis Paper. Its purpose is to analyze and describe their *AHDP* experience. The emphasis is on insight and synthesis more so than library research. Staffers are asked to integrate **theories and other information** provided in *The Staffers Manual* (Leviton, 1995), and discussed in **Training Sessions**.

The Papers[1]

All of the papers start with a description and history of the staffer's (that is the author's) member. You will read of their insights and empathy developed through the integration of physical and social activities, health education, and the one-to-one match up unique to the *AHDP*.

The first article is by Bobby Craig, a physical therapy major. A military veteran, he wished to work with a member of our Veterans Administration Nursing Home Group. Notice the change in the member's interest in his health with special reference to physical activity, social, and psychological well-being resulting from the one-to-one match up. Bobby was adept in applying our conceptual framework in working with Mr. Custer. Like the other staffers he learned to see members, clients, patients, family members, that is, all with whom we interact, as individuals with life histories, and particular needs, interests and motivations.

Jessica Frank's paper destroys some of the myths and stereotypes of people who are developmentally challenged or developmentally challenged.[2] Her member was not only fluent in Spanish but was knowledgeable and sensitive to the political climate in Cuba. He was also an accomplished artist. Even though Jessica is a Spanish major, much of what she learned about Cuba came from her close relationship with her member. She will spend the summer working at the National Council on Aging either in health policy or social work.

Tamara Staten is a junior, Family Studies major. Her interest in the health aspects of gerontology, and hospice was reinforced by her work in the *AHDP*. She, too, worked with a member with developmental disabilities. Her paper is particularly useful in her integration of our **ACAEM**, Coaching, and other concepts central to the *AHDP* in helping the member get into a health and well-being groove. They guide the staffer from an assessment of the member's needs and desires, to implementing an individualized program, its evaluation, and subsequent modification.

Debbie Guenther is a graduate health education student who worked with a member of our Community Group. Apparently, the *AHDP* experience influenced Debbie, as it has many staffers, to modify her health career goals to include working with older people.

Her member, Joan Bennett, is an example of what gerontologists call *successful aging* (Rowe & Kahn, 1998). She is physically, psychologically, and socially active, relatively free of disease or illness, and does not seem to be economically distressed. Certainly, she has something to live for, that is, prospects for the future.

The last article by Catherine Welch, a journalism major, shows how the *AHDP* can reduce or eliminate ethnic and racial stereotypes that are prodromal to hostility and aggression. From its beginning in the fall 1972, the *AHDP* has always had as a goal the elimination of people-caused deaths (that are preventable) where murderous intent exists. I have applied the label **Horrendous Death** to the entire array, and have argued that their elimination is the greatest health problem of our time (Leviton, 1989; Leviton, 1990; Leviton, 1991a; Leviton, 1992).

Discussion

As the population ages there will be an increased need for people to be knowledgeable about health aspects of gerontology, and skillful in their application to older institutionalized and non-institutionalized people. The goal? To maintain, even improve, independence and functioning of this burgeoning population with special emphasis on primary intervention. As this series of articles indicate, the *AHDP* can add to the insights, and self-efficacy of health education and promotion, and other students

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[1] Names of members have been changed. My editing of the papers has been minimal.

[2] Both terms are academically and politically correct, and are used interchangeably in the papers.

concerning health and well-being, and their application to diverse populations. It can also serve to motivate, or reinforce existing motivations of students to enter health related professions, or become advocates for older adults.

Students seem to mature from the experience. For example, Fretz, in a controlled study, examined the effect of the *AHDP* and its sister program, The Children's Health and Developmental Clinic (CHDC) on the personal development of staffers. Both groups of staffers' modal responses showed that they were more (Fretz, 1979):

1. tolerant with people.
2. relaxed with and
3. accepting of other people's problems compared to controls.

When compared to a control group, those participating in the *AHDP* showed significantly greater increases in inner directedness, spontaneity and self-acceptance (Fretz, 1979).

In another controlled study, Prather compared the effect of the *AHDP*, a **Psychology of Aging** class, and an **Economics** class (contrast group) on students' and staffers' knowledge of aging, and in their attitudes toward older adults. *AHDP* staffers, compared to students in the economics class, showed significant gain on both outcome variables (Prather, 1992).

Another significant lesson from the *AHDP*, and its related programs (the *NNIH*) is that health education and health promotion, and related fields such as physical education, recreation, and dance, have more to offer than improving the physical activity and fitness status of individuals (Leviton, 1992). They can be used to improve human relations, thus tightening the social fabric of national and global society. In this era of violence, and other preventable causes of death (that is, Horrendous Death), this would be a significant contribution to global health and well-being.

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