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for the fulfilment of the Master of Social Work (Honours)

The Coming of Age:
An academic's autoethnographic examination of gerontology education

by

Robin Harvey
(ID: 99980868)
B.Social Sciences in Social Work

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Certificate of Authorship

I hereby declare that this submission is my own work and to the best of my knowledge and belief, understand that it contains no material previously published or written by another person, nor material which to a substantial extent has been accepted for the award of any other degree or diploma at Charles Sturt University or any other educational institution, except where due acknowledgement is made in the thesis (or dissertation, as appropriate). Any contribution made to the research by colleagues with whom I have worked at Charles Sturt University or elsewhere during my candidature is fully acknowledged.

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Name
Robin Harvey

Signature

Date
6 August, 2014.
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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AAG</td>
<td>Australian Association of Gerontology</td>
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<tr>
<td>APS</td>
<td>Aged Psychiatry Service</td>
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<tr>
<td>CAP</td>
<td>Critical analytical processes</td>
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<tr>
<td>CFHCWOA</td>
<td>Committee on the Future Health Care Workforce for Older Americans</td>
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<tr>
<td>CSU</td>
<td>Charles Sturt University</td>
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<tr>
<td>EHP Commission</td>
<td>Education of Health Professionals for the 21st Century Commission</td>
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<tr>
<td>EuMaG</td>
<td>European Masters Program in Gerontology</td>
</tr>
<tr>
<td>GDS</td>
<td>Geriatric Depression Scale</td>
</tr>
<tr>
<td>H&amp;SS</td>
<td>School of Humanities and Social Science, CSU</td>
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<tr>
<td>RCT</td>
<td>Random controlled trials</td>
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<tr>
<td>SoCH</td>
<td>School of Community Health, CSU</td>
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<tr>
<td>TTC</td>
<td>Tertiary Teaching Colloquium</td>
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ABSTRACT

This thesis makes an original contribution to the under-developed field of gerontology education for health professionals, with implications for public policy and educational development. It does so by examining an academic’s experiences of becoming a gerontology educator in the current cultural contexts of health and tertiary education systems in Australia. The importance of a critical and transformative gerontology education is argued to enable health practitioners to become leaders in improving health quality, equity and social justice for older people in this era of population ageing and continuing ageism. However, there is currently little research showing how the field is responding to this imperative. The thesis uses an autoethnographic method of layered accounts to examine different perspectives on practice in a single case study, at once highlighting issues at the personal and cultural/institutional levels.

In summarising the findings of this study, a key challenge for a gerontology educator working towards transformative education is to develop pedagogy and spaces for learning that support the development of graduates as agents of change, using robust processes for critical reflection on practice and policy analysis. This may entail the capacity to broadly challenge traditional language and forms of representation of practice that obscure the voices and multiple knowledges of the practitioner and restrict them from eliciting and representing the voices of the older people with whom they work. Another critical challenge will be to assist gerontology practitioners to learn the skills of critiquing, not just policy and practice, but also the institutional and political structures that place barriers on the development of equitable and socially just health and education practices. An important challenge arising from this work is to begin to build a national collective voice to represent gerontology education and support further examination of both the current state of play in Australia and future developments to enable the transformation of health services and opportunities for older Australians.
CHAPTER 1: INTRODUCTION

Introduction

This dissertation examines gerontology education in Australia through an interweaving of evocative and reflective personal accounts of my experiences as an early career gerontology academic and scholarly analysis of the social, cultural, institutional and political contexts in which gerontology education is situated in my quest to learn more about ‘transformative’ (Frenk et al., 2010) gerontology education. The title thus represents both my coming of age as an educator and the requirement that gerontology education come of age. The latter is imperative if health practitioners are to become the agents of change called for by the Ottawa Charter and, more recently, by the Education for Health Professionals Global Independent Commission (EHP Commission) (Frenk, et al., 2010; WHO 1986), to improve health practices and opportunities for older people and promote social justice within the context of the ‘coming of age[ing]’ of the Australian population.

This research is of policy, practice and educational significance to health professionals and to the older Australians with whom they work. It is of relevance to health workforce planning and the development of appropriate education in gerontology for health professionals to meet the growing need for
speciality practice in healthy ageing and health care for older Australians. Additional key factors that give research into gerontology education its significance include population ageing and the associated health care needs and costs; the need to transform traditional social constructions of ageing that currently impact on both health policy and services for older people; and consequent workforce education policy development for an ageing population. These key areas assume even greater importance given the lack of research into gerontology education in Australia and the prevailing context of change, uncertainty, ‘supercomplexity’ and neoliberalisation within the higher education and healthcare sectors (Agbim & Ozanne, 2007; Barnett, 2000b, 2010; Loftus & Gerzina, 2013).

**Background and significance**

There are many factors that contribute to the significance of research in the field of gerontology education of health practitioners. These include: the ageing population and increasing need for health services with expertise in health care of older people; the need for constructive and informed debate on the challenges and opportunities of an ageing population and the imperative for sound policy development to address these issues; the need to counter the continuing damaging and limiting effects of ageism within health services as well as the general community; the need to improve the translation of new research on gerontological health and social issues into practice, especially where research indicates areas for health promotion and prevention of illness in
older people; and a need to develop a skilled workforce at the leadership level to drive improvements in health care and policy and to lead the implementation, in the messy and under-resourced world of practice, of new models of care, to improve actual outcomes for older people. Some of these issues are outlined in this section.

*Health and Care of older Australians*

The nature of gerontology education in Australia must primarily be informed by and appropriate to the requirements of the population of older citizens and the health system which seeks to meet their needs. The nature and dimensions of Australia’s ageing population are well-reported (Australian Bureau of Statistics, 2013). For example, the Productivity Commission reports that the number of Australians aged 85 and over is estimated to grow from 0.4 million in 2010 to 1.8 million in 2050. This figure will then represent 5.1 percent of the Australian population (2011, p. xxii). It is projected that, by 2050, more than 3.5 million older Australians will access aged care services each year and that some 80% of these services will be within community based care (Productivity Commission, 2011, p. xxii). This compares with over 1 million older people using aged care services in Australia in 2011 (Productivity Commission, 2011, p. xviii). Demand for health services (Betts, 2014; Attorney General’s Department, 2010) and gerontology educated health professionals will also increase with an older population.
The Productivity Commission enquiry into aged care reflects the concern of the, then, Australian Labor Government about the affordability of providing quality aged care in the future to a projected growing number of frail older people. However, aged care, including both community and residential care services, is only one key aspect of a range of health and social services required by an ageing population that is characterised by great diversity (Australian Institute of Health and Welfare, 2007). This diversity, combined with population wide changes in health, economic and social circumstances of Australians across adult age groups, results in a very complex picture of health in ageing (Australian Institute of Health and Welfare, 2007). The evidence on ageing associated health costs is far more complex and less unequivocal than popular discourse indicates (Coory, 2004; Healy, 2004; Poole, 2014). Other health services required by older people include the full spectrum of health care from primary health, health promotion, acute, rehabilitation and chronic care services. This range of services has implications for the roles and education of health practitioners to work with older people (CFHCWOA, 2008; Frenk, et al., 2010). Other key areas of social policy, such as retirement income, housing, transport and age-friendly environmental design also impact substantially on the health and wellbeing of older people (Australian Institute of Health and Welfare, 2007) however, for the purposes of this investigation, health care services and workers will remain the focus.
Reforming health and care of older Australians

The anticipated increase in care needs and costs for older Australians has generated many calls for systemic reform of the health and aged care sectors, with specific implications for gerontology practice and education. For example, the *Intergenerational Report* (Attorney General's Department, 2010) notes the need to increase levels of workforce participation (particularly of older people), increase productivity, maintain sustainable population growth, and to responsibly manage the spending pressures and implement health services reform (Attorney General's Department, 2010, p. xvi). However, the concomitant need for Australia to be educating leaders in health and aged care policy and practice to aid health services reform has not been addressed. The Abbott coalition government has recently announced proposed changes to health and welfare spending targeting the Age Pension and universal health care (Hockey, 2014). If implemented they will further disadvantage the poorest and most vulnerable older people, whereas alternative proposals to manage cost pressures of retirement support by, for example, adjusting superannuation tax concessions to the most wealthy (Denniss, 2013) are available. Health practitioners educated in gerontology have a strong role in advocating for the needs of older people and contributing to informed debate over policy options.

Gerontology education of professional health practitioners is essential to enable critically informed, appropriate policy and to drive high-quality and well-targeted practice in ageing health and aged care, as an integral part of achieving
meaningful reform, equitable health and social services and social justice for older people. As Russell, Mahony, Hughes & Kendig argue:

These high rates of growth [of the ageing population] have alerted an increasing number of countries in the Asia/Oceania Region to the need for planning and infrastructure development, and *the growing demand for professionals with specialised education to meet the needs of older people can be expected to increase* (2007, p. 101; added emphasis).

These are critical issues. However, as noted, ageing is not just about health care needs and dependency. Indeed, ageing for many people is characterised by a long period of independence, generativity and relatively good health (Poole, 2014). Health and wellbeing in ageing is not just a function of individual genes and lifestyle choices but is also responsive to the social and environmental context in which it is occurring and health practitioners have a role to play in advocating for healthy policy and environments in which people can age well.

*Social constructions of older Australians*

The social, policy and environmental contexts of ageing in Australia are currently dominated by, and subject to, prevailing negative social constructions of ageing, which not only maintain but also create conditions conducive to poor health and dependency in older people by limiting health expectations and health promoting behaviour of older people and health practitioners alike. The public discourse on ageing tends to strongly emphasise dependency, illness and
disability, ignoring evidence that many older people remain independent and in relatively good health until close to their death (Coory, 2004; Poole, 2014) and constitutes damaging ageism (Angus & Reeve, 2006; Greig, Lewins, & White, 2003). Ageism amongst health professionals and health services has been widely reported (eg. Angus & Reeve, 2006; Greig, et al., 2003; Harper, 2006) and creates a threefold systemic problem. It obscures the issues in policy debates about ageing by interpretations that emphasise crisis rather than opportunity for adaptation and healthy ageing (Martin, Williams, & O'Neill, 2009), reduces recognition of the way social conditions impact on ageing (Harper, 2006), and perpetuates health service systems that do not fully utilise prevention strategies or actively promote the health of older people (Angus & Reeve, 2006). Government funding has not followed rhetoric on the importance of health promotion thus retaining the health system focus on acute services that limits development of ageing well opportunities. Browning & Heine (2012, p. 99) note that: “As health professionals, we need to consider heterogeneity, individuality and the social and environmental influences on ageing that are open to intervention.” Gerontology trained health professionals should be in the forefront of challenging ageism and intervening to improve social and environmental contexts for ageing. Gerontology education is thus a matter of vital importance requiring increased attention at the level of both research and public policy and deserving of the development of a vigorous debate based on high quality research, policy analysis and specialist knowledge of gerontology. Frenk, et al. (2010) document global shortcomings in the current education of health professionals across all disciplines and specialities noting, among
recommendations for reform, the need to improve interdisciplinary education and the need to invest in the education of educators and curriculum at faculty level (p. 1951). Moreover, they urge attention to transformative education that equips practitioners to become change agents to address cultural and institutional ageism amongst other injustices facing older people. Addressing these recommendations within gerontology education will be of critical importance, given the health needs of an ageing population. It is useful to consider now how the related policy areas of aged care and health workforce development and reform address issues of gerontological health and aged care leadership.

*Gerontology workforce development and education*

Australian policy informing ageing should be seen within the broader international policy context wherein specific objectives relating to education and training of health care workers are identified as essential for achieving human rights for older people (Harper, 2006). They require a high degree of skill and knowledge in non-traditional aspects of health care. According to the United Nations, national governments have the primary responsibility for implementing the broad recommendations of the International Strategy for Action (Harper, 2006, citing UN, 2001).

The *Caring for Older Australians* report of the Productivity Commission, released in 2011, constitutes the most significant review of the aged care
industry in decades. This report, while noting that “the range and quality of aged care services have improved in past decades” (Productivity Commission, 2011, p. xviii), documents a number of areas in which current aged care services in Australia are considered to be failing to meet the health, wellbeing and affordability needs of older Australians and of the community. It states:

The aged care system suffers key weaknesses. It is difficult to navigate. Services are limited, as is consumer choice. Quality is variable. Coverage of needs, pricing, subsidies and user co-contributions are inconsistent or inequitable. Workforce shortages are exacerbated by low wages and some workers have insufficient skills. (Productivity Commission, 2011, p. xviii)

The workforce related findings indicate that quality of care is inherently related to skills and knowledge of the workforce, as well as to provision of adequate resources and appropriate models of service, however the focus of this report is on basic training for direct aged (primarily residential) care staff. This is an area of major need but should not preclude recognition of the need to further educate the professional practitioners who work within the aged care system and in health services. The skills and knowledge of workers in aged care is a function of training and education, both prior to entry to the workplace and in ongoing professional development, and is supported by workplace conditions which encourage retention of staff, with a consequent growth of practice experience. Gerontology education of aged care staff in direct care and in supervisory and management positions, therefore, has a role to play in addressing systemic weaknesses via improving the variable quality of care, addressing the skills
issues and assisting in retention of staff. The Productivity Commission made recommendations on aged care workforce training, including to expand accredited courses that provide training at all levels relevant to the needs of aged care workers, fund the development of “teaching aged care services” to train aged care workers, health students and professionals, and provide for an independent review of vocational education and training courses (Productivity Commission, 2011). The former Gillard Labor Government responded to the Productivity Commission report with the Living Longer, Living Better policy reforms and funding package which included the promise of improved access to education, training and career pathways for workers in the sector (Australian Government Department of Health and Ageing, 2012) to combat the problems of attracting, developing and retaining skilled aged care workers.

While the Caring for Older Australians report makes specific recommendations aimed at developing closer links between health and aged care services (Productivity Commission, 2011) and its workforce education recommendations could be interpreted to include specialist health professional education in ageing, the Aged Care Strategic Workforce Advisory Group (ACSWAG) final report concentrates on the aged care workforce, which is of critical importance in residential aged care. Details of a workforce supplement aimed at improving wages for aged care staff (and thus improving recruitment and retention of staff which have been identified as major problems for aged care) were announced for implementation as of 1 July 2013, (Department of Health and Ageing, 2013), however details of training and professional
education outcomes of the reform process were not addressed at that time. Following the election of the Abbott Coalition Government in September 2013, applications for the Aged Care Workforce Supplement were suspended and, while existing arrangements were to be honoured, no new applications for this funding support were to be accepted (Andrews, 2013). It seems that this tool, aimed at reducing the high turnover of staff in the aged care sector and enabling quality of care improvements, will now not be utilised. It is not yet clear what the implications of the change of government will be on training for aged care however, it seems likely that provision of training at competency levels for otherwise unqualified aged care staff will remain the priority of any training initiatives and gerontology education initiatives for health professionals to lead aged care development seem unlikely.

The need for training of unqualified aged care staff is unquestionably of high priority to improve the quality of aged care; however a strong focus on educating the range of health care and other service providers and professionals involved with older people will also be necessary. This will enable critical leadership across the sectors of health and aged care, inter-professional integration and improve the quality of health and aged care service provision to older people across all sectors. However, brief analysis of current health workforce policy suggests that there is still not convincing evidence that “the growing demand for professionals with specialised education to meet the needs of older people”, noted by Russell, et al. in 2007, is being satisfactorily addressed in Australia. This challenge is noted in the national planning of
Health Workforce Australia (HWA). However, like those coming out of the Productivity Commission (2011), the HWA recommendations focus on TAFE vocational level training and competency based workplace training (Health Workforce Australia, 2012a, 2012b). This overlooks the associated value of higher level critical interdisciplinary education at undergraduate or postgraduate health professional levels as a potential means to provide the professional practice leadership and to drive the interdisciplinary teamwork and policy development required to support these reforms. For now, it would seem that an opportunity may have been lost to embed the requirement of responding to aged health needs within these discipline specific workforce planning reports.

Australia is not alone in confronting these issues; policy approaches in the US, for example, underscore the importance of comprehensive workforce development across the aged care sector. The United States Committee on the Future Health Care Workforce for Older Americans (CFHCWOA) reports that “the need for health professionals trained in geriatric principles is escalating” (CFHCWOA, 2008, p. 123) and states that, “while the general need for professionals to care for older patients is high, the particular need for geriatric specialists is even greater” (CFHCWOA, 2008, p. 124). It also notes the need for gerontology trained health professionals to be able to lead implementation of new models of care. Reflecting on the US findings in relation to Australia further confirms the importance of research into a gerontology curriculum for
health professionals as a vital element in building health workforce capacity to effectively manage the future health needs of older Australians.

In sum, curriculum development in gerontology education for practice in Australia is clearly of importance at this time when the quality of aged care services is under review, the nature of aged services provision is undergoing reform, and the ageing of the population will continue to drive demand for additional service provision and new models of integrated health and aged services to meet the increasingly complex health issues of a diverse older population (Australian Government Department of Health and Ageing, 2012; Goldberg, Koontz, Rogers, & Brickell, 2012; Productivity Commission, 2011). The issue of appropriate specialist education for health professionals and aged care staff, while clearly critical in enabling the nation to meet stated goals for reform (Attorney General's Department, 2010; Australian Government Department of Health and Ageing, 2012), and improvement of quality in meeting the health and aged care needs of an ageing population (Australian Government Department of Health and Ageing, 2012; Productivity Commission, 2011) is not yet receiving the priority it deserves in Australian government policy or in wider debate. If not addressed this will continue to be a critical gap in efforts to reform and improve health and aged care in Australia.
Contribution to the field

In Australia currently there is a vibrant and growing body of research in gerontology and geriatrics which is providing the necessary evidence base to improve and develop health policy and health services to older people, however there is, as yet, little corresponding growth in capacity to translate this research into practice based gerontology education. There is little evidence of resources for teaching and training frameworks to enable the translation of vital new knowledge on ageing to health professionals in practice with older people. The issue of knowledge translation from research to practice is of significant concern to the Australian Association of Gerontology (AAG) which is actively examining ways in which the organisation may be able to improve this capacity across Australian health and social services (Coles, Byles, Dow, & Tavener, 2013).

Little is also known about the number or sufficiency of academic gerontology lecturers in Australia. The AAG provides brief information outlining tertiary gerontology education courses, however there is little detail on the courses (Australian Association of Gerontology, 2014b). The number of courses has grown and they vary considerably in their perspective (biomedical/social/aged services management), specific field (eg. palliative), target group (multi-disciplinary health workers or higher training for specific professions eg. nursing/aged service administration/medicine), levels (associate degree/diploma, graduate certificate/ master) and delivery (on-campus or
distance education). The AAG site includes a disclaimer that information is not comprehensive and was obtained from university website searches. There is insufficient information to provide an accurate account of the courses and the subjects offered within them. There is no accrediting body for gerontology education in Australia which might collect such data. This institutional absence also means that curricula in university courses will be varied and the adequacy is not readily determinable in the absence of any research on current gerontology curricula in Australia. In the absence of easily accessible information on the demand for education or number of gerontology graduates being produced by Australian universities (Coles, et al., 2013), the degree of match between need for gerontology education and capacity to provide it can only be speculated upon. However, there is no evidence to indicate that capacity is in any way meeting the demographic needs of training our health professional workforce in ageing. While these questions are beyond the scope of this thesis, they are indicative features of the state of knowledge on gerontology education in Australia.

Further, gerontology education is a critical area of workforce development so as to enable quality services for older people into the future, however there is minimal information about, or research into, the professional practice of gerontology educators or education for professional practice in gerontology in Australia (Coles, et al., 2013, p. S22). Surveying the broader field of education for health professionals, Frenk, et al. (2010) identify a scarcity of information and research and Loftus & Gerzina (2013) note that there is considerable scope
for research into how academics (and/or clinical practitioners) can become successful university teachers, an aspect with which this research engages. Consequently, examination of the experiences of gerontology academics, particularly those developing from a practice background, will provide new knowledge in an un-researched but important area of gerontology education practice.

Factors influencing the choice of topic

My academic interest is in teaching rather than research per se, so that I found the idea of research into teaching and education in my field to be very attractive. As an experienced social work practitioner turned gerontology educator, the nature, content and development of relevant practice-based education that can transform and enrich older people’s lives is an area of great interest and concern for me. My move to an academic career late in life was inspired by a desire to take my work with older people to a broader level in the hope of being able to assist health practitioners to work more effectively in partnership with their older clients. Hence, I have enjoyed being part of the Charles Sturt University (CSU) gerontology course during a phase of growth and consolidation, with student numbers rising from around 20 in 2007 to over 120 in 2013. The course has a social gerontology focus, is interdisciplinary and aims to make subjects practice-based, linking case based reflective processes to theory and models of practice, and flexible to meet particular student needs and interests while also developing skills in advocacy, health promotion and critical
analysis of policy. Two student/graduate surveys, in 2011 and 2013, have provided positive feedback on perceived relevance of the course to students practice needs. However, this has only piqued my interest in exploring the possibilities for further development of curricula and teaching practices to better meet the needs of these health practitioner students and the older people with whom they work. I wish to transcend the ‘celebratory accounts’ (Groundwater-Smith & Mockler, 2007) that have arisen within the institution in recognition of student growth as a measure of success to critically consider my journey as an academic within the development of the course. In so doing, I hope to inform the next part of the development journey and perhaps the journeys of others.

I am also an active member of the AAG Victorian Division Executive Committee, which is the predominant organisation supporting research and education in ageing in Australia. The absence of a network of gerontology educators, as opposed to researchers, within the organisation with whom to pursue my interests in curriculum development and pedagogy for practice based education has also prompted my focus on ‘speaking this world’ as a way of reaching out to potential colleagues and collaborators on this issue. These factors have guided my choice of topic.
Structure of thesis

The thesis has begun by broadly outlining factors that make the education of professional health practitioners in gerontology a significant issue for the future of health services in Australia and situating my interest in this enquiry. Chapter Two reviews literature relevant to transformative gerontology education, including literature associated more broadly with practice based education of health practitioners. The literature is organised using Frenk et al’s (2010) framework of informative, formative and transformative education. Chapter Three outlines the research design employed to answer the research question arising from the literature review: *What are an academic’s experiences of teaching gerontology to diverse practitioners in Australia and how can these experiences contribute to the potential for transformative education in gerontology for health professionals?* It introduces and justifies the methodology selected to examine this question, namely autoethnography. This relatively new methodology is discussed in relation to its relevance to this study and the specific method of layered accounts is outlined. In Chapter Four the layered account illuminates elements of my pre-academic practice, examining my motivation for moving into academia and some of the practitioner knowledge I was able to bring to the new role. The second layered account informing Chapter Five examines an experience of professional development in teaching early in my academic career. Finally, Chapter Six presents the key findings of this study and implications for future research and development of gerontology education.
The thesis uses both a traditional structure and voice in the introduction, literature review and methodology chapters before incorporating evocative writing about practice, or what Richardson & Adams St. Pierre (2005) describe as creative analytical processes (CAPS), as data, in chapters 4 and 5. These chapters write me into the thesis as researcher/subject to offer a personal account and analysis of my academic journey.

Conclusion

The teaching of gerontology to health professionals is a matter of growing significance in Australia and globally. Gerontology is both a speciality area of health and a broad interdisciplinary area of social study which is of considerable importance to all people who live long enough to age, (and that is an increasingly large number in a globally ageing population) and to health workers, governments, policy-makers and tax-payers around the world. As the population in Australia ages, health professionals will be working with an increasing proportion of older people within their caseloads and the health and aged care service systems will require increasing resources to meet the health and care needs of older Australians. The future economic impact of the ageing population is a hugely complex issue which is currently exercising governments around the world, not just in relation to health care but also in relation to employment and productivity, retirement incomes and participation in the social and economic life of the community. Within this context, Australia needs
health professionals with a thorough and critical interdisciplinary gerontology education (Frenk, et al., 2010) to lead clinical best practice with older people and to guide, inform and advocate for transformative policy responses to these issues which maximise participation and wellbeing of older people within a supportive community and productive economy. The following chapter examines what is currently known about transformative gerontology education in order to identify how the study can best contribute new and significant research to this field.
CHAPTER TWO: LITERATURE REVIEW

Introduction

This chapter reviews literature on gerontology education practice, with a particular focus on material relevant to the needs of Australian students, who appear to be increasingly existing health practitioners enrolled at post-graduate level via distance education (Coles, et al., 2013, p. 43). The review is divided into two parts that canvass a) educational practices and b) the institutional contexts in which they are located. In the previous chapter, the case was made that to meet the needs of an ageing population, Australia requires investment in gerontology education that will develop health practitioners who are able to critique the systems in which they work and to offer policy and practice solutions to improve the experience of ageing and opportunities for healthy ageing – that is, to initiate positive change. Frenk et al’s (2010) three-part health education framework speaks to this imperative and is employed to organise the analysis of the state of knowledge on informative, formative and transformative gerontological education. Within this section the pivotal place of practice-based education is highlighted and literature from cognate health fields is drawn upon to discuss gaps in the gerontology specific literature on this topic. Greater attention is given to the transformative element of the framework given it is the least well developed. Overall, this section reveals that there is
much as yet untold in the story of gerontology education, with the existing literature being largely descriptive and de-contextualised. Hence, literature on the institutional and academic contexts within which gerontology education occurs is reviewed in order to better explain the state of knowledge in gerontology education.

Despite the identified need for significant change in the broad and important sector of gerontology education, the EHP Commission notes that there is a global scarcity of research on health professional education (Frenk, et al., 2010), which includes gerontology education. The international literature on tertiary gerontology coursework education for health and aged care practitioners indicates a diverse, fragmented and under-developed field (Maiden, Horowitz, & Howe, 2010; Politynska et al., 2012) with reports of significant sustainability challenges for gerontology education programs (Askham, Gilhooly, Parkatti, & Vega, 2007; Gilford & Frank, 2006). As yet there appears to be insufficient capacity to meet the growing requirement for health professionals specialising in gerontology to address the ageing of populations (Gilford & Frank, 2006; Hietanen, Lyyra, Parkatti, & Heikkinen, 2012; Maiden, et al., 2010). For example, the international literature on gerontology education, including the international journals Gerontology and Geriatrics Education and Journal of Educational Gerontology over the past 10 years, reveals surprisingly little research on postgraduate gerontology education, given its fragile state. The field is even less developed in Australia.
An early review of gerontological knowledge development in Australia (Howe, 1990), concluded that education was emerging from a period wherein research had been unduly narrow in scope and resultant gerontological knowledge focused on instrumental value, rather than on its potential to examine and construct social meanings of ageing (p. 145). Howe contended that education was then poised to become a significant force in shaping the development of the discipline (p. 141). In hindsight this predication seems to have been overly optimistic. Little literature on gerontology education was discovered from current Australian sources. For example, a literature search on higher education in the premier peer-reviewed publication in this field, the *Australasian Journal on Ageing*, during the last 10 years (2003 – October, 2013) found only one article on tertiary gerontology education, a recent article discussing the history of ageing research and education in Australia (Coles, et al., 2013), plus several articles on teaching in geriatric medicine (Duque et al., 2013; Watson, Massarotto, Caputo, Flicker, & Beer, 2012). Further, in research presentation abstracts at the 45th AAG National Conference, held in November 2012, little content specifically on gerontology education for health professionals /aged care was offered. One symposium reported on a particular “teaching aged care facility program” and a themed group of five presentations focused on workforce issues, but from a worker transitions and workforce retention perspective rather than an education needs or practice perspective (AAG, 45th National Conference proceedings, 2012). Lack of knowledge about current teaching curriculum in Australia is a crucial gap in information and itself constitutes a barrier to the sort of informed and robust national and international
debate about what health professionals need to learn about gerontology which needs to be building momentum now in order to meet the future requirements of our ageing population. Overall, the recent increase in gerontology education courses, (from 6 Master level courses in gerontology, geriatrics, aged care or related fields in 2007 (Russell, et al., 2007) to 17 such courses in 2012 (Coles, et al., 2013, p. 43) does not appear to have been either as a result of, or accompanied by, coordinated research and information on the curriculum and methods required to meet this growing demand for specialised education.

In sum, minimal published work addresses the nature, role or key elements of gerontology education, current curriculum or educational practices. Hence, the review draws on practice-based education literature for health professionals to explore issues of pedagogy relevant to gerontology education.

**Gerontology education practice**

In this section, The EHP Commission’s three-part (informative, formative, transformative) educational framework is applied to the gerontology education literature. It is noteworthy, that three highly similar tripartite models have been employed by several other scholars analysing curriculum and knowledge for health practice (Barnett & Coate, 2005; Hutchings, 2010; Titchen & Higgs, 2001). The synergies between these models reinforce the appropriateness of analysing literature on the different, but overlapping, components of gerontology education and broader practice-based health education.
Firstly, Barnett and Coate’s (2005, p. 2) model discusses tertiary curriculum for health professional practice education as comprising three dimensions which help form curricula. These are the dimensions of knowing, acting and being. ‘Knowing’ refers to the technical or discipline specific knowledge required for practice in the health professions, ‘acting’ refers to behaving with professional skill in ways which enable professional practice roles to be performed well and ‘being’ is about the professional need to be aware, engaged and focussed, as a whole person in partnership with the patient or client, in the ‘knowing’ and ‘acting’ of professional practice.

Secondly, Titchen and Higgs (2001, p. 215) contend that experienced health practitioners blend three types of knowledge effortlessly. These types are propositional knowledge, professional craft knowledge and personal knowledge. Propositional knowledge can be defined as scientific or theoretical knowledge, professional craft knowledge refers to the systematic observations and reflections on professional experience that inform practice, particularly about how to use propositional knowledge, and personal knowledge refers to what practitioners know from their whole of life experience about working with people and about using their own personal capacities and managing own limitations.

Thirdly, Hutchings’ (2010) work on transformative learning offers a very similar differentiation of practice knowledge. It is based on a head, hand and heart typology. This approach identifies ‘head’ knowledge as what we need to
know as experts, ‘hand’ knowledge as how to apply this knowledge in action and ‘heart’ knowledge as how to engage with people ethically and appropriately.

In sum, the three models align closely to the EHP Commission’s framework (Frenk, et al., 2010). Informative (expert) education is echoed in the knowing, propositional and head elements of the other models (Barnett & Coate, 2005; Hutchings, 2010; Titchen & Higgs, 2001). Formative (professional) education reflects the acting, professional craft and hand elements, while transformative (change agent) education speaks to the being, personal and heart elements. The first element draws attention to questions of ‘what’ knowledge should be included in gerontology curricula at the level of informative education, whereas the second and third elements focus on ‘how’ gerontology professionals practice with older people and ‘how’ they learn these aspects of their practice knowledge and learn from their practice. These models recognise that it is not enough to teach people generalisable knowledge. It is also vital that people learn how to create and practice knowledge from their own experiences within a context of constant change and ongoing age-related discrimination and injustice.

A key message from each of these authors is the importance of all elements of education being integrated by situating and developing learning within and through practice experience that is contextualised, critically and creatively reflective, and collaborative (Higgs & Titchen, 2007). Transformative learning
is viewed as the highest level of attainment building on informative and then formative learning. The merging of learning layers necessarily means that the borders between informative, formative and transformative elements are blurred, rather than rigid. The transformative goal of creating leaders and change agents rests heavily on grounding learning in local conditions of practice through the forging of “collaborative and non-hierarchical relationships”, teams, alliances and networks underpinned by values of critical “social accountability” (Frenk, et al., 2010, p. 1924). The following section considers the extent to which the gerontology education literature speaks to these three elements of learning and knowledge.

*Informative and formative elements of education*

The gerontology literature is saturated with informative knowledge that underpins ‘what’ is taught in the discipline. Gerontology is a very broad and complex field, which encompasses knowledge about ageing, older people, health and aged care from a vast range of disciplinary perspectives (eg. biomedical, neurological, psychological, economics, geographical, epidemiological, sociological, environmental, information and technology, architecture, politics and policies are just some possible perspectives), and considers a life-course perspective of influences on ageing (such as early and midlife), as well as ageing health, and environmental issues, retirement and age-friendly environments) (Hooyman & Kiyak, 2011; Novak, 2012). Gerontology also encompasses the spectrum of health interventions from
primary care, through acute, chronic, rehabilitation and restorative, long-term, residential to palliative care and the application of health promotion perspectives at each of these stages and directed at individuals, groups and communities (Hooyman & Kiyak, 2011). Gerontology knowledge includes the social determinants of health (issues such as gender, sexuality, socio-economic class, culture, metro/rurality, structural aspects of society) which intersect with ageing to amplify or reduce risk factors, and it includes understandings of the diversity, strengths, resilience, purposes and productivity of older people as well as of the risks and potential health issues and illnesses associated with ageing. Different models and tools for practice include person-centred care, evidence based care, case management, interdisciplinary teamwork (CFHCWOA, 2008) and different broad service types include health, social services, community care and residential care. The multidisciplinary nature of gerontology (Angus, 2009; Coles, et al., 2013; Hooyman & Kiyak, 2011) and diversity of students have already been noted. While the diversity and complexity of the field is highly significant and the research base comprehensive and building (Coles, et al., 2013), there is little investigation in the literature about what is currently being taught in gerontology courses internationally and even less known about what is being taught in Australia beyond what university websites afford the persistent searcher (Coles, et al., 2013).

Nonetheless, the extant literature suggests the existence of a fairly ad-hoc range of curriculum practices. For example, in the US, the CFHCWOA identifies
“inadequate and variable curricula and clinical experiences” (2008, p. 123) as one of the problems in achieving an appropriately trained workforce for the ageing population. It recommends that education for health professionals “needs to be expanded both to take into account the diversity of health care needs among older populations and to prepare professionals for the coming new models of care, many of which will require changed or expanded roles” (CFHCWOA, 2008, p. 123). Of specific note it suggests the following areas for inclusion in curriculum: “interdisciplinary team care; care management; chronic disease self-management; pharmaceutical management; preventive home visits; proactive rehabilitation; caregiver education and support; and transitional care” (CFHCWOA, 2008, pp. 94,95). In Europe, the EuMaG program addressed curriculum via four main domains – bio-gerontology, social gerontology, psycho-gerontology and health gerontology (Aartsen, 2011) – a schema which appears broad enough to potentially include most aspects of ageing required by practitioners of health disciplines to work effectively with older people. Although new models of care, such as person-centred care and restorative approaches to rehabilitation, have been changing the rhetoric of health and aged care services and personnel in Australia, there has been no systematic or case study research on the informative content of gerontology curriculum in higher education.

Although the gerontology literature is less forthcoming on the formative elements of education, the broader health professional practice education literature (eg. Higgs, Barnett, Billett, Hutchings, & Trede, 2012; Loftus &
Gerzina, 2013; Titchen & Higgs, 2001) abounds with material on ‘how’ to act professionally, which Frenk et al (2010) see as the key formative objective. In particular, there is little gerontological research on the tertiary education of experienced professional practitioners compared to entry-level student practitioners. Practice centred postgraduate curricula for practitioners who can build on their own current practice as material for learning receive little attention. Within the larger body of research, interdisciplinarity illustrates a component of formative education.

Gerontology education needs to produce practitioners who understand both the specific propositional or informative knowledge of their discipline in relation to ageing and the broader context of ageing and health and who can also work effectively in teams with members of other disciplines. Bass and Ferraro (2000) argue that the diversity of focus within gerontology opens a further argument as to whether the field can or should move from a multi-disciplinary to an interdisciplinary and integrated paradigm. Skinner (2001) provides a useful definition of the terms multi-disciplinary and interdisciplinary as follows:

… “multidisciplinary” refers to “different disciplines involved in the same task and working alongside each of them but functioning independently.” “Multidisciplinary” does not imply any particular commitment to collaborative work or a common understanding of the professional standards of the disciplines involved (Queeny & Castro, 1990). “Interdisciplinary” also requires the presence of more than one discipline as a
prerequisite in the study of complex problems, but relies on the interdependence of disciplines working together in the search for solutions to these problems (2001, p. 74).

For gerontology education, then, the task is to educate practitioners from diverse disciplines in integrated ways that increase their capacity to understand a broader range of knowledge about aging, promote their attitudes and ability to collaborate with other practitioners and to jointly create solutions to complex problems. While recognition of the need for interdisciplinarity in gerontology education is wide-spread, the development of relevant curricula has received less attention (Skinner, 2001). Interdisciplinary gerontology education requires formative educational experiences of working together professionally (using craft knowledge) and collaboratively (using personal knowledge) to resolve complex practice issues of health in ageing. Angus (2009) describes a gerontology curriculum focusing on leadership for dementia care practice that provides opportunities for students to work both autonomously and within an interdisciplinary student team in order to develop interdisciplinary solutions to complex problems and to develop the capacity to intervene in organisational contexts in order to facilitate institutional and social change (p. S19). These skills are equally as relevant to health professionals engaged in any aspect of health services for older people.

Coles, et al. (2013) identify interdisciplinary education in gerontology as a key future direction for Australia, and Frenk et al (2010) identify interdisciplinary teamwork as a key competency of practice to be required as an outcome of
health professional education. Both these authors conclude that there is significant progress required before interdisciplinarity in gerontology and health professional education might be achieved. Achievement of goals of interdisciplinarity in gerontology will require transformative education to enable practitioners to overcome and change the traditional professional discipline boundaries; however the literature focuses on formative education as a means of developing professional attitudes and skills towards collaboration.

If a gerontologist is defined as “someone who is committed to the science of aging” (Sterns & Ferraro, 2008, p. 7), it must be harnessed to serve and benefit humanity, thus gerontology has a strong focus on application in practice and is interventionist (Sterns & Ferraro, 2008). Renold (2000, p. 19) notes that gerontology is a rapidly evolving field therefore gerontology education needs to be dynamic in order to adapt to and incorporate new research knowledge and practice models. The recommendations of the CFHCWOA, for example, certainly acknowledge the need for gerontology education to produce practitioners able to adapt to change (formative education) but appears to fall short of advocating for practitioners who can lead the changes, thus requiring transformative education.

*Transformative elements of education*

The gerontology education literature indicates a significant gap in addressing transformative education. This gap is of crucial significance if gerontology
education is to live up to the need to produce gerontologists who are not only expert in the field and ethical professionals, but will also be able to act as change agents to improve social justice and health equity for older people in this time of widespread challenge and opportunity associated with population ageing. How might gerontology education meet this challenge? How can we teach people to be change agents and, indeed, practise as change agents ourselves within our roles in gerontology education? Or, as Angus (2009) writing specifically about post-graduate dementia services curricula development in Australia asks,

\[how\] do we go about empowering practitioners to become students (or learners) and then turn them back into a different kind of practitioner - a leader in the field – who has acquired the capacity to lead and innovate, everyday? (p. S19)

This section explores some potential elements of transformative education for gerontology practitioners, drawing in particular from critical gerontology. The discussion will be situated within a critique of the power imbalances that exist between older people and the systems that offer health and care services to them.

Critical gerontology arose as a radical alternative to and critique of the “conventional ‘social problems’” approach to aging (Moody, 2008), and constitutes “a more value committed approach to social gerontology – a commitment not just to understand the social construction of ageing but to
change it” (Phillipson & Walker, 1987). While critical gerontology defies narrow definition, it can be broadly understood as an approach to ageing that promotes social justice by focusing on social constructions of ageing and applies a critical perspective to the social, economic and political contexts which shape individual aging experiences (Minkler & Holstein, 2008; Moody, 2008; Phillipson, 2008). This is an approach to gerontology that sits well with the requirement for health practitioners to be transformative change agents (Frenk, et al., 2010). Whereas it has previously been focussed at the level of broad critique of the social conditions that limit older people, Moody suggests that achieving the emancipatory ideals of critical gerontology may be best done through adding another layer that focuses on the level of “everyday meaning-making” of individuals where he claims “human agency is universally expressed” (Moody, 2008, p. 205). Accordingly, gerontology practitioners should be able to act from a critical perspective that opens up understandings of inequalities in ageing, to promote the unique and diverse voices of marginalised individual and groups, in order to contribute to practical problem solving of oppressive conditions of ageing.

The kind of transformative learning envisaged by Frenk et al (2010) in which practitioners are change agents advancing “an ‘emancipatory gerontology,’ which identifies issues of social transformation at the core of its work, is some distance from being achieved” according to Phillipson (2008, p. 168). Phillipson and other critical gerontologists, often inspired by the gerontology scholar activist Maggie Kuhn, pursue a vision of gerontology practitioners that
see them as reflective change agents that recognise and challenge the social control and power embedded in their own positions as practitioners and educators. In 1978 Kuhn penned an open letter to the US Gerontological Society outlining this position as explained by Estes:

She [Kuhn] urges Gerontological Society members to engage in “participatory radicalism” by working “with the oppressed rather than for the bureaucratic world which regulates the oppressed and determines the condition for their survival”. She charges that, “To the extent that gerontologists fail to challenge the system and its social controls, they become agents of social control for older people” (Estes & Portacolone, 2009, p. 21).

Critical gerontology seems to offer gerontology education an overarching framework within which to situate transformative knowledge about power and inequality, to critique social, economic and political structures that shape ageing and to develop the capacity to become agents of change.

In their analysis of “civic engagement” of older people as a developing trend in the US, Minkler and Holstein (2008) demonstrate some tools of critical gerontology that could be part of a transformative curriculum. These include critical questioning of ‘the way it is’, of the way policies and systems impact on the personal and individual such as: paying attention to issues of definition and terminology which shape an issue; identification of master narratives within cultures that prescribe how ageing should be enacted and of subgroups that do not fit this prescription and may be marginalised by it; examination of the
political ideologies supporting an issue or position; questioning who stands to benefit economically from a particular policy or issue; and what may be unintended consequences. These are some of the elements from a critical perspective that could be linked with the sort of skills Kuhn called for - in advocacy, reflective practice and activism to empower older people to speak out, individually and collectively, in preparation for gerontology roles as agents of change.

Very few gerontology scholars have seriously engaged with transformative learning issues. One who has examined learning in terms that seem to fit this definition is Angus (2009), whose case-study on leadership in postgraduate gerontology (dementia services) curricula offers a number of recommendations for practitioner education aimed at re-shaping aged services. She highlights the key role of ethics as “the heart of leadership” and “the governance of care” and sees the need for education to provide a safe environment for robust conversations about applying ethics in practice, and developing personal and organisationally supported values about caring, honour, integrity, tolerance and mutual respect, whereby students can grow in ethical practice as they exercise leadership within their organisations. Similarly, Langer (2000) discusses the need for social gerontology students to learn to resolve ethical dilemmas in practice at a variety of levels, including within social policy, planning and research in addition to direct care. These priorities are more common in the wider health profession literature such as the work of Guillemin, McDougal and
Gillam (2009) which advocates “ethical mindfulness” as the aim for continuing ethics education for practitioners.

Key processes for learning leadership, according to Angus (2009), include the use of critical reflection techniques and case-studies. Critical reflection on own practice assists students to make the difficult decisions that abound in practice and in management and “open[s] up their learning, by questioning existing methods and relationships and by questioning what is taken for granted” (p. S20). Critical reflection, importantly, engages the student’s critical faculties in relation to their own attitudes, actions and knowledge in practice as well as in critiquing “dominant practices”, organisational and social policies and methods as context for their actions in practice. Angus (2009, p. S20) claims that critical reflection is a “tool of persuasion to promote values and to change attitudes – to challenge and make changes in institutions of caring that are often entrenched in hierarchical and mono-disciplinary traditions.” She also emphasises the value of a two-way exchange of ideas between teacher/students, grounded in shared experiences of practice, and notes that course content reflects “the importance of the practical evidence from within the dementia field of practice to inform education and research” (2009, p. S22). Angus sees teaching in gerontology as a two way process which values, utilises and shares students own practice experience, alongside research based knowledge, and the practice experience of the teacher, to jointly build new practice knowledge and skills of leadership to reshape their professions and organisations. These skills would seem central to
responding to Maggie Kuhn’s call to action to work with the oppressed and against social control of older people.

The embryonic work of Angus and others on the transformative aspects of gerontology education align with influential critical approaches within the wider educational scholarship. This is particularly exemplified through the “pedagogy of care” that Barnett (2007) urges educators to adopt in their dealings with students. His elements of a pedagogy of care read very much like a call for solidarity with older people and students. In this respect, Barnett’s work is in the tradition of one of the great exponents of transformational education, Paulo Freire, and his critical pedagogy approach to learning, that emphasises personal experience and voice as a critical first act of power (Labonte, 2007) and the role of the educator to enable the student to “speak their world.” Likewise, Barnett (2007, p. 126) seeks to “release” students “will to learn” so as to become “more authentically” themselves in and through their learning. His pedagogy of care for teaching students in the prevailing conditions of uncertainty emphasises relationality, a mutual engagement of communication, emotion and sensitivity to the ethical (Barnett, 2000b, p. 157). He contends that the key to teaching may be the capacity of the educational experience to both energise and set free the student to become more authentically his/herself in pursuit of his/her own learning. The way in which this transformation takes place is via the interrelated ideas of critical being and of enquiry in the spirit of research (Barnett, 2007, p. 127). The concept of critical being refers to an ability to stand apart from one’s self and reflexively
examine one’s thoughts and actions and the consequences of these in our experiences. It is a way of being reflective and accountable to oneself for one’s own learning and goes hand in hand with the idea that what underpins learning in whatever experience, field or discipline is “enquiry in the spirit of research” – an openness to questioning and a motivation to find out (p. 127). Barnett claims that these two activities support an authenticity (of learning and of being) which is only ever developed over time and through sustained engagement with uncertainty.

The uncertainty principle reaches deeply into the student’s being. Students complain about their uncertainties, their doubts about their abilities, their concerns that everything in their minds is a muddle or just won’t straighten out, but one of the achievements of higher education is precisely that of enabling students to live with their own inner turbulence and to realise that it will always be thus. There is no resting place from here on. Incessant turbulence is a price of realizing the idea of higher education (2007, p. 127).

Barnett (2007) describes pedagogical care as including concepts such as ‘nurture’ (as both a process and an act, over time and requiring commitment of the teacher to both the field of enquiry and the student); ‘solicitude’ (a form of care for the student in which the teacher envisages future possibilities for the student and opens doors for the student to pass through according to a student’s own choice of direction); a ‘will to teach’ (which has to be sustained within the many competing demands on teachers in the higher education system and can
only be sustained through “durable dispositions on the part of the tutor”); ‘institutional solicitude’ (in which the university has ‘dispositions’ in place to support students and help them forward); ‘additional reciprocity’ (the interwoven nature of teaching and learning between teacher and students, arising from an openness of the pedagogical relationship in higher education and the reciprocity that “out of the giving comes more giving, out of the daring, more daring. This is a pedagogy of risk”) (p. 132); and a ‘will to gift self’ (a notion related to ‘pedagogical friendship’, which describes a relationship in which both the student and the teacher gift their engaged selves in pursuit of the learning) (Barnett, 2007, pp. 127 - 136).

Barnett’s vision of teaching and learning as a transformative process, requiring these elements within a reciprocal relationship, may perhaps be also usefully viewed as modelling of a potential approach to working with older people that could be personally transformative and ‘co-productive’ for both ‘client’ and health professional. Barnett’s emphasis on enabling the student to find his/her own will and authentic learning direction raises the issue of power to frame the educational process. Who defines what needs to be learned? Student or teacher directed curriculum? Barnett clearly comes down on the side of student directed learning, but how does this work in practice, within the prescriptive institutional contexts of tertiary education, professional accreditation and workplace requirements of health professionals? In the case of gerontology, Russell et al (2007) contend that changes are required to university culture in respect to academic practice and management in order to address issues such as this and
enable sustainability “to meet the post-graduate study needs of working professionals” (p. 110). The differentials of power between student and institutions are significant and Barnett’s invocation of the concept of co-production does not make clear how this gap might be bridged.

The term ‘co-production’ can be defined simply as “the joint production of services by the system and the user” (Lee & Dunston, 2010, p. 64), but has far more profound and radical implications for redefining the relationships between individual health professionals and health consumers and within organisational and system level practices. Co-production extends the concept of user/consumer participation to include participation in the whole range of design, development, delivery and evaluation of services and redefines the nature of health “professional expertise and responsibility within models of care that seek to be co-productive” (Lee & Dunston, 2010, p. 61). However, health service users, professionals and system managers/governments may have very different interests and imperatives in relation to health service provision and there are major power differentials in these relationships, with the user of health services having very little power in relation to the other stakeholders. While the concept of co-production does not offer a ‘quick fix’ for the challenge of such power differentials, it makes a start by disrupting the taken-for-granted nature of provider-centric and professional expert perspectives. This implies the need for gerontology students, as health professionals to be able to understand and identify the nature and distribution of power within the system and in their own roles in order to be able to actively and effectively choose where they stand in
relation to this power. Co-production approaches could, at least, produce gerontology professionals who choose to support service users and disrupt the status quo where changes are needed to improve the quality of services.

Gerontology professionals’ approaches to dominant forms of knowledge and evidence are one issue that may warrant transformative leadership. In a health service context where evidence-based practice is the required standard, the ‘gold star’ evidence is that from random controlled trials (RCT’s). It has been argued that RCT’s have become almost the only acceptable research model in many health fields, but that there are many aspects of health, and in particular health promotion, which cannot be tested in this way (Binns, Jancey, Howat, & Carter, 2012). However, within evidence-based practice there is scope for a far wider definition of evidence and judicial use of information in decision-making than simply that from RCT’s (Hoffmann, Bennett, & Del Mar, 2010; Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, p. 71). Nonetheless, there remains a prevalence in health systems of a “narrow view of evidence-based practice in which research evidence is the only evidence that counts” (Titchen & Higgs, 2001, p. 218). This is one example of the need and challenges for transformative education in the gerontology field.

Numerous obstacles have impeded the maturation of gerontology education into a field that consciously and seamlessly integrates informative, formative and transformative dimensions. These include the breadth and diversity of curriculum content required; the diversity of personnel working in the field of
Teaching, learning and knowledge production, occur in the current era of what Barnett identifies as “supercomplexity”, which demands a “a pedagogy for uncertainty” (2000b, 2007, 2010). Within the university we are experiencing a new world order, in part due to globalisation and the information technology revolution, in addition to other forms of social change. This new world order not only challenges traditional forms of knowledge but also the existence of universal truths and of single ideas or sets of ideas which can be followed as a reliable guide forward into the future (Barnett, 2000b, pp. 3,4). In explaining his concept of ‘supercomplexity’ Barnett notes that
It is that form of complexity in which our frameworks for understanding the world are themselves problematic. It is that form of challenge in which our strategies for handling complexity itself are in question. It is a higher order complexity in which we have to find ways of living and even prospering, if we can, in a world in which our very frameworks are continually tested and challenged (p. 76).

Barnett (2000b) emphasises that supercomplexity does not mean that there are no solutions to the problems with which we grapple, rather that there are many possible solutions, many of them competing, and none of which we can say, with any certainty, is the correct and final solution because from each solution will arise new problems and new potential solutions ad infinitum. It is this condition, where the only stability is change and uncertainty – also a key implication of neoliberal market policies – with which Barnett contends that academics and students must engage.

In short, professional life is increasingly becoming a matter not just of handling overwhelming data and theories *within* a given frame of reference (a system of complexity) but also a matter of handling multiple frames of understanding, action and of self-identity.

It is this multiplication of frameworks that I term *supercomplexity*. It increasingly characterises the world in which we all live. Working out its operational, cognitive and
pedagogical implications for the university constitute much of the challenge ahead (Barnett, 2000b, pp. 6,7).

Barnett argues that, under conditions of supercomplexity, traditional notions of teaching and learning are “in trouble” (Barnett, 2000b, p. 153). He asks what teaching and learning means in an age when “every utterance, every frame of understanding, every action, every value system and every state of human being are challengeable and are challenged...” (p. 153). How do we teach in an era where the state of knowledge changes and where many traditionally fixed and ‘universal’ principles are revealed to be transitory and relative? In answering this question, Barnett suggests:

In a supercomplex world, the key challenge is not one of knowledge but one of being. Accordingly, the main pedagogical task in a university setting is not that of the transmission of knowledge but of promoting forms of human being appropriate to conditions of supercomplexity (2000b, p. 164).

Therefore, like Eraut (2001), Higgs and Titchen (2001) and Frenk et al (2010), Barnett (2000b) rejects the notion that teaching ‘knowledge’ is the whole story (or even the most important chapter) in higher education today. Barnett makes a case that professionals need to learn ways of being and acting which will enable them to operate effectively within this context of uncertainty and change. He proposes that university education needs to “unsettle” students in both their minds and beings by enabling them to see how the very frameworks within which they understand the world are challengeable and not fixed and secure.
Students need to *experience* uncertainty within their education to learn how they might *be* and *act* effectively within a context of uncertainty as professional practitioners. Barnett (2000b, p. 155) cautions, however, that students must also be reassured (not left anxious and uncertain). Yet, despite the centrality of relationships to transformative learning, clients, health practitioners, students and gerontology educators are rarely given voice in the gerontology education literature.

Relating this conception of education being undertaken within conditions of supercomplexity to a student cohort of health practitioners in ageing services, it is possible to identify further aspects of uncertainty particular to this context. The exact consequences of an ageing population are not clear, however findings from research into age related issues at a wide range of levels and within many disciplines are contesting traditional knowledge of ageing and older people and challenging ageist assumptions about ageing (Coles, et al., 2013; Harper, 2006; Katz, 1996). Within service systems, organisational models, practices and roles are being questioned in a managerial search for greater efficiencies (Davies, 2003) and the limitations of policy debates in the political arena on how to provide health care for an ageing population (as expressed, for example, in the 2014 national budget (Hockey, 2014)) create significant uncertainty about future directions for the health system.

These factors also raise urgent questions about how this pedagogical relationship of care, built on these principles might be able to be enacted within
a contemporary university, an educator’s workload, and the particular complexities of a student cohort, which are superimposed upon the prevailing supercomplexity of academic and professional life. The simplicity of pedagogical care principles belies the time and energy required to enact them. Angus (2009b) indicates an example where two-way pedagogical relationships that may approximate Barnett’s (2000b) pedagogy of care underpin teaching but other examples are scarce. Authenticity requires time to engage fully as a human being as well as a teacher. Relationships which encourage and sustain a ‘pedagogical will’ (Barnett 2000b) require time and commitment, as well as openness to challenge and debate, which, themselves, require time and commitment. How can these principles be enacted within the neoliberal framing of time which Davies and Bansel (2005) argue:

...ties individuals and organisations to the chaos of the market and, in the interests of driving those individuals and institutions in directions favourable to the market, it regulates, controls, standardises and pressurises. [...] with the outcome of pushing academics to the point where they simply cannot accomplish what is expected of them in terms of quantity and quality (p. 49).

However, the under-development of gerontology education and the pedagogical directions conveyed in the foregoing literature tend to skim over the institutional contexts in which these principles do or might occur.
These contexts comprise an important untold dimension of the state of gerontology education and the experience of gerontology educators. For example, a successful University of Sydney gerontology program is no longer offered, having been closed in part because of the retirement of a key gerontology academic (Russell, et al., 2007; Simpson-Young, pers. commn. 16/5/13). Russell et al almost foreshadow this outcome in their warning of “the need for significant and sustained investment in both human and technological resources” (2007, p. 109) and avoidance of the unsustainable “Lone Ranger syndrome” (Bates in Russell, et al., 2007, pp. 109-110) where sole academics develop (online) programs. While Russell et al were referring primarily to the development of online curriculum and use of technology for teaching, the point is potentially just as relevant to overall academic participation in gerontology education in Australia, where gerontology is not a well-established academic discipline and gerontology academic careers are primarily to be found in research rather than teaching. This lack of academic faculty appears to leave some teaching programs to rely on individuals, or a very few academics, for their development and or continuance (eg. CSU, University of Sydney), creating significant vulnerability for these programs. This echoes the situation in America, identified by the CFHCWOA (2008a) where a lack of academics trained in gerontology education is noted as a key factor limiting gerontology education, and in Europe (Askham, et al., 2007). The following section considers the contours of that institutional landscape and the challenges and questions it raises for those working at the coalface.
Institutional context

Far from the flourishing field that might be expected to flow from a high priority issue such as an ageing population, gerontology education has been floundering. Stearns and Ferraro (2008) document the development of gerontology education in the US over the past 30 years, identifying an era of rapid growth and funding support for new gerontology courses during the 1960’s and ‘70’s, followed by a sharp retraction of funding in the early 1980’s that has continued to leave gerontology education in the balance. The development of teaching gerontologists and faculty is identified as a critical issue for the future of gerontology education and, within the range of different levels and types of gerontology education in the US, coursework Master level education targeting existing health practitioners is noted as being of value for producing specialist health practitioners able to meet the challenges of an ageing population. (Sterns & Ferraro, 2008). These trends coincide with a period of neoliberalisation of public health and education (Deem & Brehony, 2005; Etzkowitz, Webster, Gebhardt, & Cantisano Terra, 2000; Marginson & Considine, 2000).

The predominant neoliberal political and cultural influence on higher education in Australia over the past three decades under successive Liberal and Labor governments, has seen a reduction in public funding of Australian universities at the same time as an increased demand has been imposed to educate more students (Agbim & Ozanne, 2007; McInnis, 2000). The resultant hegemonic
systems of management which operationalise this particular ideology of governance of public service organisations has had major impacts on the education sector and, subsequently, the sectors in which graduates are employed, such as public health. For example, Davies (2003) contends that the shifts in power and control associated with neoliberal ideology may well be the most significant that professionals will ever experience, being defined by the removal of power and authority from the knowledge of practising professionals and its transfer to “policy-makers, auditors and statisticians, none of whom need know anything about the profession in question” (p. 91). Agbim and Ozanne (2007) note the duality of neoliberal pressures where both of the critical sites in the case of social work education, being universities and human services organisations, have felt the impact of corporatisation, increasing managerialism and bureaucratisation of organisations and changing relationships between professionals, consumers, policy makers and the state (p. 70). Gerontology higher education is similarly dually affected by managerialism, both within universities where teaching is undertaken, and in the fields of health and human services where practitioners studying gerontology do and will work. However, gerontology, as a new and interdisciplinary specialisation, is even less able than other established professions, like social work, to call on the legitimacy of professional or disciplinary bodies to ameliorate these neoliberal conditions. The relative powerlessness of the gerontology discipline has no doubt influenced how gerontology educators are tackling the pedagogical challenges, yet little is known about their experiences.
Universities subject to the neoliberal project have been described as ‘enterprise’ and ‘entrepreneurial’ universities (Barnett, 2010; Etzkowitz, et al., 2000; Marginson & Considine, 2000; Slaughter & Leslie, 1997). The former is characterised by strong executive controls and a corporate structure owing less to business than to an “‘ideal type’ corporation modelled on public sector reform” (Agbim & Ozanne, 2007, p. 71). They argue that definitions of quality and accountability are taken from the private sector, as are the culture of consumption, and a “pseudo-market” of education based on fee income and insecure earnings from student enrolments and research grants in competition with other universities (p. 71). Under such market conditions, it may be difficult for a new discipline, such as gerontology, to attract students initially, in order to gain and retain university funding, in competition with more established courses which have well-known, high status and high remuneration professional employment outcomes. It may be that the corporate culture of the university, where student demand drives funding and supply tends to act against the development of new courses like gerontology, and high student fees reduce the capacity of health workers from lower socio-economic backgrounds who often make their way into lower paid professions, such as aged care nursing, to access and thus create demand for such courses (Stokes & Wright, 2010). It seems that there may be little capacity, under such a culture, for the established social need for gerontology specialists in health professions to become a driver of appropriate gerontology education.
The entrepreneurial university is defined as one which undertakes activities aimed at enhancing regional or national economic performance as well as being to the economic advantage of the university itself and its faculty (Etzkowitz, et al., 2000). This definition is based on what these writers called ‘the triple helix model’ of increased collaborative interaction between the university, industry and the state. Phillpot, Dooley, Riley & Lupton (2011) argue that the need to contribute to economic development has been added to the traditional missions (of knowledge transmission through education and knowledge creation though research) of those universities which have embraced the entrepreneurial university model. The entrepreneurial university is concerned with maximising the external impact of knowledge and it’s use and usefulness in the world (Barnett, 2010). In focusing on the exchange value of knowledge in the world, its primacy as an economic commodity is necessarily foregrounded. While there is a strong argument for the usefulness of gerontology education, and a large potential target market amongst health professionals working in the area of aged services, the fact that the majority of health care and services for older people are conducted within an underfunded public sector, makes gerontology education a less profitable and desirable commodity within this culture (Johnstone, 2013). Ultimately, the marketisation of universities is leading to the abandonment of one of the most important goals of education: the aim to build knowledge for the good society (Ekstrand, 2013).

For academic staff, these neoliberal conditions have created a long list of consequences for the nature of their work, including: increased difficulty in
negotiating the competing roles and tasks of teaching, research and the expanding category of “other work”; increased managerial surveillance over academic work; reduced critique and responsible dissent; reduction of collegiality between individual academics, between academic/managers and academics, and between different academic faculties (sciences and technology as opposed to humanities), which have differentially taken up the neoliberal discourse under conditions of economic competition; increased workloads for academics; a decrease in time spent teaching and reduced quality of teaching; increased pressure to be individually entrepreneurial and bring in new funds for research; increased individual responsibility and accountability for producing economically sanctioned ‘products’ via teaching and research in the context of reduced resourcing; technologies, accountabilities and bureaucratic procedures have added new responsibilities to academics; increased levels of stress amongst academics; greater reliance on sessional teaching staff; increased diversity of teaching modes, including multi-campus delivery and distance education (Agbim & Ozanne, 2007; Davies, 2003, 2005; Davies & Bansel, 2005; Davies & Petersen, 2005; Deem & Brehony, 2005; McInnis, 2000).

While gerontology academics would be no different from other academics in experiencing many of these factors, there are several which may particularly impact on them. The reduction of collegiality between faculties in an era of competition for funding is particularly significant due to the interdisciplinary nature of gerontology, which requires collaboration across a broad range of academic disciplines in order to thrive. The increased emphasis on research and ‘economically sanctioned products’ at the expense of teaching will also
negatively impact gerontology education. There is a strong, well-established and growing gerontology research community in Australia, with 20 AAG Collaborating Research Centres listed nationally as of February 2014. However, the lack of corresponding development of gerontology education and teaching in the university reflects the over-emphasis on research noted by these authors. There is little in the gerontology literature which directly addresses the implications of these issues for gerontology educators.

Nevertheless, there are significant implications for the advancement of gerontology education. For instance, collegialism within the academy seems to be increasingly limited and subject to managerial and administrative control; a matter of some importance for a relatively fledging discipline. Davies and Petersen (2005) suggest that on the contrary, under the auspices of neoliberalism, academics are required to become competitive individuals focussed on producing products prescribed by government. In so doing, there is a substantial risk that they will be unable to accomplish “significant, creative or critical intellectual work” (p. 78). Coady (2000) argues that universities have lost those “intellectual and cultural traditions” that engender and support the complex work of intellectual endeavour (p. 24). Davies and Petersen (2005) argue that, in particular, the intellectual traditions of critique and informed dissent are curtailed within the need to conform to performance indicators, which measure only recognised and sanctioned activity. Further, the new performativity lines up the individual’s products and their value in order to demonstrate alignment with government rather than dissent. The dissenting
ones, who do not have the correct products, can be placed in line for redundancies and other forms of negation (Davies and Petersen, p. 95). Hence, the prevailing neoliberal market orientation of the university sector is a potential challenge to the meaning and authority of learning and knowledge, from the modernist role of the academy as guardian or steward of the integrity of knowledge to a role of purveyor of knowledge subjugated to the power of the consumer (Sappey & Bamber, 2007), where performance indicators are geared to customer satisfaction. Interdisciplinary teaching in gerontology is thus required to meet the ‘customer’ expectations of a wide range of students from different professional backgrounds and different fields of work – a complex task for educators – which may or may not equate neatly with the interests and needs of older people as understood from a critical gerontological perspective. Within this organizational culture, it is not surprising that interdisciplinary gerontology education, as a new field of teaching, which crosses traditional faculty boundaries and has no professional body to support its legitimacy, and which lacks the cachet of being able to provide a sanctioned profitable product (ie. graduates for a profit-making industry), appears to be largely invisible in the literature and within the broader Australian academy.

**Conclusion**

In conclusion, there is a significant gap in the literature in relation to gerontology education, that is particularly evident at the level of addressing the sort of transformative education that Frenk et al (2010) argue is necessary for
health professionals to be able to contribute to improved health, equity of health
and social justice. These issues are explicitly relevant to the health of older
people as we negotiate national and global population ageing within cultures in
which ageism and marginalisation of older people is still dominant. Katz (1996)
for example, argues for an activist, applied gerontology that not only researches
the important issues of ageing, but acts to change these for the better. He
finishes his critical gerontology treatise with the words of Simone De Beauvoir
who, in 1972, issued a call to action which is still highly relevant today:

> Once we have understood what the state of the aged really is,
> we cannot satisfy ourselves with calling for a more generous
> ‘old-age policy’, higher pensions, decent housing and
> organized leisure. It is the whole system that is at stake and our
> claim cannot be otherwise than radical - to change life itself


Examination of the very limited gerontology education literature indicates that
the complex neoliberal circumstances in which educational and health
advocates for older people are now operating poses substantial obstacles to
heeding these messages. Yet, it is notable that Frenk et al (2010, p. 1925) give
only cursory attention to these institutional factors in their report, choosing
instead to refer only to health professionals’ complacency as a cause of
inaction:

> Health professionals have made enormous contributions to
> health and development over the past century, but complacency
> will only perpetuate the ineffective application of 20th century
educational strategies that are unfit to tackle 21st century challenges. Therefore, we call for a global social movement of all stakeholders—educators, students and young health workers, professional bodies, universities, non-governmental organisations, international agencies, donors, and foundations—that can propel action on this vision and these recommendations to promote a new century of transformative professional education.

In the case of gerontology education at least, the absence of educators’, students’ and older people’s voices from the literature means that charges of complacency are unsubstantiated and hence unhelpful. If gerontological health professionals are to respond to such calls to action, then their lived experiences of attempting to develop transformative curricula and foster such relationships with students, within current institutional and structural contexts, need to be better understood. Much of the foregoing educational practice literature is aspirational in nature, depicting what gerontological education should look like. There is an urgent need to understand what gerontological educators are actually doing to achieve these goals and how they are attempting to overcome the many barriers to doing so. This thesis makes a contribution to this hiatus in the gerontology education picture through an in-depth case study exploration of one gerontology academics efforts to build transformative teaching and learning experiences. Hence, the research question driving this study is: What are an academic’s experiences of teaching gerontology to diverse practitioners in
Australia and how can these experiences contribute to the potential for transformative education in gerontology for health professionals?
CHAPTER THREE: RESEARCH DESIGN

Introduction

In the first chapter I established that substantial attention is being paid by governments and health policy organizations to the prospect of an ageing population (eg. Attorney General's Department, 2010; Australian Government Department of Health and Ageing, 2012; Family and Community Development Committee, 2012; Health Workforce Australia, 2012a; Productivity Commission, 2011) however, the parameters, consequences, opportunities and policy adaptations required to address this are too often being obscured by the dominance of an ‘ageing crisis’ rhetoric that owes more to ageism (Martin, Williams, & O'Neill, 2009; Poole, 2014), ideology (eg. Hockey, 2014) and unquestioned assumptions (Coory, 2004; Healy, 2004; Poole, 2014) than to the research evidence available to guide sound policy. In this environment of public discourse that marginalizes sound debate on health and support for older Australians it is vital that health practitioners develop not only specialist disciplinary skills to meet the health needs of older people but also interdisciplinary skills in critical analysis, advocacy, collaboration and policy reform to drive improved and more equitable health services and opportunities for older Australians. Gerontology education that is not only informative and formative, but also transformative (Frenk, et al., 2010), will be necessary to
achieve this. The literature review has further established that gerontology education is a complex, important and, as yet, under-researched field and that little is known specifically about gerontology academic practices in teaching diverse health practitioners in interdisciplinary practice nor about transformative education in this context. These gaps in knowledge point to a current need for exploratory research that may clarify the nature of this field and be able to generate rich data from which to develop further, more specific, research questions and projects.

This chapter outlines the research aims and question and explores autoethnography as an appropriate qualitative methodology to address them. The relatively new methodology of autoethnography is briefly explored and its choice as the methodology for this study justified. The particular autoethnographic method selected for this study, that is layered accounts, is introduced and its application in this study detailed, including discussion of ethical considerations.

Research question and aims

The literature review conveyed the embryonic state of gerontology education scholarship, notwithstanding urgent policy and social imperatives relevant to this field of inquiry. It highlighted the emphasis on informative and formative curriculum and the comparative neglect of transformative content alongside the relative absence of gerontology educators’ voices. As noted, gerontology
teachers and learners have yet to speak of their worlds substantially. These circumstances underscore the need for contributions to the scholarship from those working at the coalface, with particular attention to the change agency aspects of their experiences. Given the limited resources and scope of this study, the thesis seeks to make a contribution to this research gap by investigating the following research question: *What are an academic’s experiences of teaching gerontology to diverse practitioners in Australia and how can these experiences contribute to the potential for transformative education in gerontology for health professionals?*

More specifically, the aim of my research is to identify and analyse my own experience as a health practitioner become gerontology educator within the political, social and cultural contexts of the health and higher education systems. My purpose is to open up my experience to critical reflection and analysis against a background of scholarship in teaching and learning for professional practice in gerontology, generating rich case-study data that provokes further questioning and research in search of transformative education. I aim to produce simultaneously a work of scholarship of learning and teaching within neoliberal (Davies & Bansel, 2005) and uncertain times (Barnett, 2007), and a critical and reflexive case-study in order to both learn from my varied experiences as a developing practitioner/academic and to grow beyond these experiences in my role as a teacher and partner in learning with my students. As indicated in Chapter One, it is hoped that the outcomes of my research will potentially inform the development of other new academics
entering the field of gerontology in Australia and of health practitioners seeking to extend their own learning and identities as gerontologists.

**Autoethnographic methodology**

Autoethnography offers a valuable methodology for addressing these aims and the research question. It is a relatively recent and developing range of research practices stemming from ethnography. Ethnography is a method of research which enables the examination of a singular set of experiences as data, for example, those of a novice academic learning about teaching and curriculum development for professional practice in gerontology, within a broader social and institutional context, and the implications of these experiences. Hammersly (cited in Granger, 2011, p. 27) describes ethnography as “a research method useful for producing “theoretical”, “analytical” or “thick” descriptions… [that] remain close to the concrete reality of particular events [while revealing] general features of human social life.” Autoethnography refers to a form of ethnography which focuses on the narrative experiences of the researcher as data and, working within the social science tradition, combines this with cultural analysis and interpretation in an attempt to develop rich understandings of the issue being researched (Chang, 2008).

Autoethnography makes possible the simultaneous examination of an individual case or event and the social, political or cultural contexts in which this individual case is situated and shaped. It thus weaves back and forth
between the personal and the social in examining individual representations of
social and cultural worlds through reflective and analytical processes, with
differing emphases. It can be defined as

...the study of a culture, cultural group, community or
institution, such as education, by a “full insider”. It
“(re)position[s] the researcher as an object of inquiry who
depicts a site of personal awareness; it utilizes the self-
consciousness… to reveal subjectively and imaginatively a
particular social setting”. By turns both autobiographical and
ethnological, it may emphasize one or more segments of its
tripartite name: the research and writing process, the culture or
institution being examined, or the individual engaged in it. It
connects the personal and the social through narratives that
illumine relations between them (Granger, 2011, p. 31; original
emphasis).

Hughes et al (2012, p. 212) emphasise that autoethnography begins with the
comprehensive formulation of social problems and Muncey (2010, p. 28)
suggests that it is one of the ways in which researchers seek to express the
complexity of personal experience within the ‘messiness’ of social science
research.

Autoethnography also enables examination of the voice and experiences of the
researcher to become central to the research, thus departing from traditional
ideas of researcher as outside of, and objective from, the research, and challenging this paradigm of objectivity (Granger, 2011).

Autoethnography contests the modernist ideas that researcher and subject, or object, of research are distinct from one another in an absolute sense, as well as the notion that interpretation is a neutral exercise producing transparent knowledge and objective truth (Granger, 2011, p. 33).

Autoethnographic inquiry goes against this tradition and attempts to enable ways of representing the object of research as it is being experienced by the researcher, thus it makes transparent the nature of all research – that it is “both an incomplete and an interested account of whatever is envisioned” (Brodkey in Granger, 2011, p. 33; original emphasis).

Autoethnography therefore enables a personal researcher perspective and a sociological perspective to interweave and reveal rich descriptions of a niche or singular experience which, in turn, generates interpretations which may have meaning and relevance for a wider societal perspective. This method clearly does not afford generalisability as traditionally understood, however this does not negate wider social relevance, which may be achieved due to the originality of experience and the framing of new insights, questions and ways of analysing the experiences that may speak, and bear relevance, to the reader. Generalisability and validity are not sought through random sampling and other procedural methods, but can be assessed by the reader in respect of the relevance of the ideas, questions and insights derived from and provoked by the
Autoethnographic study to the reader’s own world and work. Autoethnographers must describe not only the events, issues and artefacts of data but also the researchers personal, cultural and political position, values, the methods and processes of study and responses and changes in focus as the study proceeds, in sufficient detail that the reader is able to decide whether the findings may apply more broadly and resonate within the readers experiences (Hughes, et al., 2012).

Autoethnography arose in conjunction with the understanding of the impossibility of deriving a single master-narrative to explain any particular social science phenomena (Ellis, Adams, & Bochner, 2011). Granger (2011) notes:

> Sometimes one person’s remembered story, or interpretation of that story, can inform and even nourish another’s memory, story or interpretation, even if on their surfaces they are quite distinct. This is my first wish: that the moments I recall, narrate, and interpret may open up possibilities for others to think in similar ways about different moments in education, or in different ways about similar moments, or even about different moments in different ways, because sometimes there are surprises (pp. 10, 11).

This memory work is based on a social constructionist perspective that highlights the integration of the cognitive and the social elements of memory (Kippax, Crawford, Benton, Gault, & Noesjirwan, 1988). This perspective
addresses both the intrapersonal cognitive elements of forming memory and the processes of self-appraisal and reappraisal that interprets meaning and emotion in the context of social representations and cultural norms. It is argued that these processes of appraisal and reappraisal according to implicit social norms shape the memories that we store and reproduce (Kippax, et al., 1988).

Within the elements of story – characterisation, detail, and the clarity and authenticity of a personal voice in the research writing – rich descriptions are created which, by engaging with the readers own experience, open up such myriad possibilities for new thinking.

The autoethnographer like other of his qualitative counterparts can convey the kind and degree of evidence to readers that invites them to compare their own lived experiences and contexts of interest to those conveyed by the author(s) (Hughes, et al., 2012, p. 215).

My own experience of reading autoethnographic studies in preparation for this thesis endorses the claim that engaging stories about another’s practice have both inspired me and evoked numerous questions and ideas about my own work even when there has been no immediately obvious link between the practice fields.

Anderson (2006) and others have sought to differentiate between what they term ‘evocative’ and ‘analytical’ forms of autoethnography, which can be seen as a continuum with some overlap between forms, rather than a discrete
distinction. Denshire (2009) notes that the binary classification between evocative and analytical autoethnographic approaches is useful, primarily as a way to illuminate the differences in how autoethnographic writers integrate their dual foci on self and cultural contexts. For example, Richardson & Adams St. Pierre (2005) employ ‘creative analytical processes’ (CAPs) in their work. They endorse the postmodern claim that “writing is always partial, local, and situational and that our selves are always present” (p. 962), if only partially so, as in most academic writing, parts of our selves are repressed to maintain a fiction of objectivity. Understanding this concept offers the freedom to write texts in a variety of ways, and to tell and retell, thus creating different versions of a story which are neither the ‘right’ nor the ‘wrong’ versions, neither the only truth nor fiction. Instead they offer “differently contoured and nuanced” (Richardson & Adams St. Pierre, 2005 p. 962) accounts which have the capacity to reveal other, valid and desirable understandings of the social, that “invite people in and open spaces for thinking about the social that elude us now” (Richardson & Adams St. Pierre, 2005, p. 962). In accordance with the name, CAPs include both creative and analytical elements which may be assembled in a variety of ways, in order to offer critical reflection and reflexivity in relation to a vivid, engaging and thick description of practice.

Further, autoethnography lends itself to examination of the local, the normal, the alternative, the everyday and otherwise unrepresented aspects of events and experiences which may reveal important information about what is really going on (Muncey, 2010, p. 34). In her “autoethnography of learning, teaching and
learning to teach” (cover subtitle), Granger offers one way of exploring these unrepresented experiences by examining what she describes as “silent moments in education”,

when what is supposed to happen doesn’t happen: when curriculum or pedagogy is resisted, refused, denied; when learners become stuck, frozen, or paralyzed; when the self, as learner or teacher, grows silent (2011, p. 7).

Such moments are ‘silent’ not only because the self may be lost for words due to disruption of the expected, but also because these moments are rarely recorded or examined, they may go unnoticed or may have been excluded from the official organizational record of events. In applying this notion of silent moments to my experience of teaching gerontology at CSU, it is apparent that there are many moments of difficulty, barriers, challenges and breakthroughs inherent in my development, as both teacher and student, which have been neither documented, or explicitly acknowledged or otherwise made accessible as sources of learning. Granger (2011) emphasizes the relevance of an autoethnographic approach which examines the ordinary, the difficult and the challenging in teaching, within its particular setting and context. She contrasts what she sees as the predominant view of contemporary Western teaching and learning (that successful outcomes are almost guaranteed once the currently favoured technical strategies and standards are in place) with the diversity and complexity of factors impacting on learning and teaching and the people engaged in these processes in any particular institution and across time, that ultimately often render technical solutions largely ineffective.
Autoethnography’s premise is that not only difficult moments, but also everyday or ordinary moments that have the potential to inform specific practice, also pass unnoticed while the insights to be gained from their examination go unrecognized (Granger, 2011) and simplistic organisational celebratory accounts (Groundwater-Smith & Mockler, 2007) go unchallenged. Another way of thinking about unrepresented aspects of experience is via the metaphor of “white spaces” (Cherry, 2010). Cherry notes that graphic designers focus on the white spaces which are around and outside of text or symbols on the page. “These white spaces start at the boundaries of what we know or can express and so provide a powerful metaphor for the potential of the unknown” (p. 10). Focusing on the white spaces, or the absences, in official documentation of experience, as a research practice sounds a little like ‘reading between the lines’ but in fact requires rigorous examination of a text to identify areas where the story is incomplete, the context not discussed, assumptions not clarified and/or where some information has been privileged over other alternative data or interpretation. She explores the challenges inherent in professional practice within contexts of complexity, “where data and know-how are either limited or ambiguous and conflicting” (Cherry p. 9) and maintains that this complexity provides distinct opportunities for qualitative research in the white spaces. By establishing socially contextualised insider perspectives, autoethnography facilitates closer attention to the unheard, unseen and unnoticed behind-the-scenes lived realities of organisational, institutional and
professional cultures in arguably greater depth than many other qualitative methods allow.

The methodology also has high applicability for examining professional practice experience. According to Peseta (2005), autoethnography enables accounts of practice that reveal the “human-ness” of the work. Denshire (2014, p. 8) concurs that the methodology can be effectively used to produce ‘transgressive’ accounts that challenge the orthodoxy of dominant representations of professional practice and unsettle the “proper” in “the ethical relations of self and other” by offering alternative knowledges. The connections between the reflexive narrative account and the social/cultural context in an autoethnographic study may be generated and examined in different ways or by using a range of different social theories for analysis, including examining structural and political issues. The methodology is flexible in that it does not require a particular theoretical perspective to be used, but to achieve these various insights does require that the processes which generate the formulation of the problem, the selection of material as data, selection of theoretical perspectives (where applicable) as tools of analysis and the processes of interpretation, be clearly documented and presented as a coherent account of the research methodology (Hughes, et al., 2012).

The absence of a robust body of scholarship and research on gerontology teaching and curriculum for health practitioners, on which to ground my research, makes this exploratory methodology, with its potential for use of my
own experience as data, an appropriate research option. The undeveloped field of practice of gerontology education is suited to this methodology in that it has the capacity to use the gaps in knowledge (the white spaces) as a starting point and my everyday experiences (the silent moments) as data to examine this field. The selection of an autoethnographic approach for this study was also guided by its usefulness in producing an in-depth investigation of otherwise unrevealed aspects of everyday gerontology education practice and meaning-making in a single case (my practice) that may serve to generate insights for my future teaching and be of use to novice gerontology educators. Its value in exploring these facets of experience is acknowledged in educational, teaching and learning research generally (Ellis, et al., 2011; Granger, 2011; Hughes, et al., 2012, p. 210) and is, by definition, suited to examination of individual practice development (Denshire, 2009; Granger, 2011; Peseta, 2005).

Autoethnography is useful to my investigation in that it opens up a space of inquiry, writing, representation and communication about an experience that is atypical or ‘transgressive’ (Denshire, 2014), outside of the ‘normal’ accepted experience understood and validated within the academic collegiate and the health professions. It seems that my experience as both a practitioner become academic and as a gerontology academic in a small interdisciplinary space outside the established disciplinary departments of academia is neither typical nor represented elsewhere, perhaps even transgressive. It provides a way to illuminate my singular experience within an inquiry which places this experience in contrast or opposition to the accepted culture of the university but
in a context of analysis of both individual practice and institutional culture rather than as a simple narrative of difference. Hence, this methodology can help examine the construction of knowledge in gerontology education (Granger, 2011) by exploring issues of multiple, alternative or contrasting narratives and representations of events or experiences and for critiquing practitioner enquiry (Denshire, 2009). Autoethnography makes visible a different experience and representation of learning and being within an organizational culture (in this case, higher education) that is highly codified, and where experience is often assumed to be shared by all in the collegiate. Thus autoethnography may reveal new, fresh or contested perspectives of value to developing a rich description of the professional practice field under study (Denshire, 2009).

While qualitative interviews with other gerontology educators could provide insights into these issues, several factors made autoethnographic methods more feasible for this examination. As noted, given there is no organised Australian network of gerontology educators in higher education and little consistency of location of gerontology programs or staff tenure within university faculties, recruitment of potential participants with lengthy and detailed engagement with gerontology education would have been beyond the resources of this study. Further, interview data does not allow the same level of in-depth analysis of the person in context that an autoethnographic approach can deliver, according to Anderson (2006), who claims that autoethnography has the capacity to drill more deeply into how meaning-making occurs than other qualitative methods.
allow. While autoethnography encompasses a range of possible approaches, ‘layered accounts’ is one method that allows the research question to be creatively and appropriately engaged so that a gerontology teacher, and through me, gerontology learners are able to starting speaking our worlds.

**Method: Layered accounts**

The particular method of autoethnographic research I am using is classified as a ‘layered account’ (Ellis, et al., 2011) in which texts written from different perspectives are collected, examined and connected in fresh ways to highlight a range of interpretations and possibilities within described phenomena (Denshire, 2009). Goodall (in Denshire, 2014, p. 13) describes a layered account as one that demonstrates “connections among personal experience, theory and research practices” as the researcher draws on and moves between textual narratives and reflections on those narratives, thereby challenging the notion, and resisting production, of a single story from a sole viewpoint. According to Ellis, et al. (2011, pp. 278, 279), layered accounts

…focus on the author’s experience alongside data, abstract analysis, and relevant literature. This form emphasises the procedural nature of research. Similar to grounded theory, layered accounts illustrate how “data collection and analysis proceed simultaneously” (Charmaz, 1983, p. 110) and frame existing research as a “source of questions and comparisons” rather than a “measure of truth” (p.117). But, unlike grounded
theory, layered accounts use vignettes, reflexivity, multiple voices, and introspection (Ellis, 1991) to “invoke” readers to enter into the “emergent experience” of doing and writing research (Ronai, 1992, p. 123), conceive of identity as an “emergent process” (Rambo, 2005, p. 583), and consider evocative, concrete texts to be as important as abstract analyses (Ronai, 1995, 1996).

Layered accounts include alternative voices and/or viewpoints and may include fictive tales which express a previously unheard, and close to ‘real’ experience version of events or ‘real’ personal experience remembered and reflexively analysed and juxtaposed with cultural context and analysis. Many autoethnographers endorse the postmodern understanding that all ‘truth’ is only partial and situated and hence that fictive tales based on experience may be as ‘truthful’ as memories, interviews or other representations of reality (Denshine, 2009; Ellis, et al., 2011).

Data collection

In this research process I use, as data, four texts that I have written over a period of years and that have relevance to my research question. They form two layered accounts of practice, which constitute the two analytical chapters to follow. Each layered account consists of a pair of texts that are different in style, representation, chronology and purpose. An ‘original text’ written as part of my professional development some years ago is contrasted with an ‘untold
tale’, that is, a text written specifically for the purposes of this layered account that tells of alternative perspectives, addresses gaps and untold stories of the original text. These pairs of texts are then ‘read against each other’ (Denshire, 2009) and examined using critical reflection on my practice and analysis of the broader social, cultural and political contexts in which these texts were written and my practice performed. Together with introductions to locate the two texts within my practice at the time and conclusions identifying key elements of learning from the data, these elements form the layered accounts chapters.

As noted in a layered account method, data collection and analysis occur simultaneously, but are explained here separately for ease of understanding. The original text constitutes both data for analysis and a starting point for the generation of additional data (emerging from the gaps in the original text) in the form of the untold tale which is written to make possible further and deeper analysis of the two texts. Hence, the selection of the ‘original text’ for each account needed to convey something of relevance to the research question about my gerontology teaching or practitioner experience. Autoethnography typically utilises texts that speak to periods of transition or connection. For my purposes, I sought original texts that were associated with moments of learning (‘light-globe’ or ‘penny dropping’ moments), of illumination and growth; transition points in my practice; resonance between my learning/teaching and that of my students; connection of my learning/teaching with practice; shifts in my professional identity within/between practitioner/academic; or witnessing professional identity. I also sought texts that were written for formal use by or
purposes of the organization, not just between myself and student(s) or myself and client(s), to facilitate organisational and institutional critical reflection. In writing the *untold tales* I have used, previously discussed, creative analytical processes (CAPs) (Richardson & Adams St. Pierre, 2005) in a retelling of the original experience from a different perspective. The memories written into this *untold tale* can be viewed as, at once, personal and socially located and co-produced.

*Layered account I: ‘Wonderful, brave, together’*

The first layered account is entitled ‘Wonderful, brave, together.’ The *original text* on which it is based is a ‘GER assignment’, written as an assessment item for a subject when I was a student in the Master of Health Sciences (Gerontology) program in 2006, that addressed a health promotion topic using my previous work with the Healthy & Wise program as a case study. This text relates to each of the selection criteria. Healthy & Wise was a profoundly important period, rather than moment, of learning and growth in my practice. My ‘GER assignment’ in particular addresses criteria of transitions in practice and professional identity. It represents a time when I was in transition between (and inhabiting concurrently) roles as a health practitioner, new academic and higher degree student. Because of these multiple roles, I felt that my GER assignment revealed resonances between my own teaching and learning at that time and those of my now current practitioner-students- another criterion for selection as an original text. My ‘GER assignment’ is a formal text, written for
the organisational purposes of assessment of my learning, and that explicitly sought to connect my learning, as a gerontology student, with my prior practice as a social worker/health promotion worker and, as such, could be expected to reveal comparisons and changes in my professional identity as a practitioner, my identity as a student and as a new academic.

The *untold tale* ‘Wonderful, brave, together’ was written in a single session. In a change to the planned sequence, it was not so much written ‘against’ an examination of the original text, as per my intended process but in a spontaneous and unstoppable response to a supervision session planning my thesis. It seems that this project released an untold story that had been waiting to get out and be heard and that, on examination, constituted an appropriate *untold tale* to match with the *original text*. Writing the tale that has become ‘Wonderful, brave, together’ was my first intentional experience of what Richardson calls “writing as a method of inquiry” (Richardson & Adams St. Pierre, 2005, p. 960), whereby writing, as a particular use of language, is not a passive reflection of social reality but rather “produces meaning and creates social reality” (Richardson & Adams St. Pierre, 2005, p. 961). Adams St. Pierre goes on to use Richardson’s idea of writing as a “field of play”, in which we might loosen the hold of received meaning that limits our work and our lives and investigate “to what extent the exercise of thinking one’s own history can free thought from what it thinks silently and to allow it to think otherwise”
The writing of this _untold tale_ did, indeed, free me – from writing in a formal academic style and from using the knowledge I thought I already had about the program as my subject – and, in doing so, opened up my understanding of the Healthy and Wise program in new ways that I instantly recognised as authentic to my experiences but had never before been able to clearly articulate. The process of writing not only captured previously untold experiences but also, in ‘writing otherwise’ enabled me to see new details and patterns in these experiences and generated new understandings. In this instance, writing allowed me to ‘think otherwise’ and produce ‘Wonderful, brave, together.’

*Layered account II: ‘Where do I stand?’*

The second layered account, entitled ‘Where do I stand?’ begins from an _original text_, ‘TTC report’, which was written in 2008 as a hurdle task to pass the professional development program for early academics at CSU. This text also meets the criteria for selection in that it deals with another professional transition, that of practitioner to academic and teacher and, locating myself, again, in a ‘learning’ situation, may be expected to enable reflections and analysis that directly illuminate issues of value for my own students. I re-read this report applying a critically reflective gaze before writing an _untold tale_, also entitled ‘Where do I stand?’ that represents my previously unrepresented experience of the program in detailed, personal and comprehensive form.
‘Where do I stand?’ is written from memory and foregrounds significant emotional content from the perspectives of myself as author, and my perceptions of the emotions of others in the tale. The third person (‘Robin, ‘she’, ‘her’), rather than the first person (‘I’ and ‘me’), was used intentionally in this account, in accordance with guidelines for memory work established by (Kippax, et al., 1988), who suggest that this is a useful strategy to promote, in so far as possible, the point of view of an outside observer with the aim of “uncover[ing] the social meaning embodied by the performances described in the written account” (p. 23). The shift in tense from the subjective to the objective contributes a different perspective, wherein the very act of writing requires a greater degree of measure and reflexivity (Kippax, et al., 1988). As Richardson & Adams St. Pierre, 2005) remind us “Language is a constitutive force, creating a particular view of reality and of the Self” (p. 960). The use of third person in this tale also offers a contrast in techniques to the first person tense used in the text ‘Wonderful, brave, together’.

Ethical considerations

Although the researcher is the only ‘participant’ from which data is sourced in autoethnography, ethical considerations can be complex within this approach. Given that “an autoethnographer might have rights to his or her story [but] so do the others mentioned in the text”, there are particular ethical issues which must be addressed in the planning of autoethnographic research. Tolich (2010) has suggested ten foundational concepts for ethics in autoethnography that
focus on consent, consultation and vulnerability. This study conforms to these guidelines. Consultation with a range of representatives of the School and University ethics committees at CSU was conducted prior to submitting the minimal risk ethics application. Informed consent was not a requirement of the ethics approval, as within the layered accounts method there was only one research participant (me) and only one set of experiences studied (mine).

A focus on the researcher’s own narratives and experiences as data, however, will rarely be to the exclusion of others appearing in these accounts, even if only incidentally. Smith (1980, pp. 228-229) reminds us that “every telling is produced and experienced under certain social conditions and constraints and that it always involves two parties, an audience as well as narrator.” In the case of planning the proposed research, it was imagined that academic colleagues may appear in the narratives, either directly or by implication. Ethical issues may arise even when the other is anonymous, as it may be possible for a reader to identify that person from other narrative details (noting the event or organisational structures, for example). Incidental characters in my tales of practice were, in the case of ‘Wonderful, brave, together’, de-identified and written as composite characters whose dialogue and actions, although based on real memories, were blurred by both time (more than ten years past) and by deliberate rewriting to maintain anonymity. Details have been changed to protect identities, the descriptions of places and events in the story have also been altered to provide anonymity, but are faithful, in essence, to the memories I have of real events. I hope and intend that these characters honour the
strengths and struggles of both the particular and the many courageous women participants from whom they are drawn. The dialogue included is fictional, as, from this distance in time, I cannot recall specific words and phrases, nor would I choose to quote if I could, but it represents the essence of what might have been said in this situation by one or some of the women. It is my story, based on my memories and a version of events, as I perceived them then, overlaid with my current perceptions looking back. Other participants would have different memories and stories to tell. ‘Wonderful, brave, together’ holds the seeds of many stories, glimpses of many women. It is not the whole or only truth. It is not even the whole truth or reality as I perceive it, but rather a fragment of my experiences, told in a certain way, looking back from where I am now, as a gerontology academic in a regional university. There was no requirement for consent in this case.

Incidental characters in ‘Where do I stand?’ (facilitator, presenters, colleagues) were provided with an information letter about the project as an expression of respect and in accordance with the ethics committee requirements, and asked to elect whether they wished to be named or referred to by an alias. I sought, in my writing, to avoid making anyone incidentally mentioned vulnerable in any way, maintaining anonymity for participants and only representing incidentally those colleagues whose roles were absolutely necessary to my story.
Data analysis

Using the layered account method of retelling a tale and then re-reading it in conjunction with an earlier version of events, there are multiple audiences as the narrator/researcher necessarily acts as both writer and audience, in the first instance, in order to analyse the texts. The two texts in each layered account are examined against each other, using critical reflection and analysis. Reading the two texts against each other is a multiple process of re-reading each text in a series of comparisons, searching for the obvious levels of similarity or difference but also for the things left unsaid in each, the assumptions untested and the ‘news of difference’ where the ‘known’ or expected or dominant discourse is disrupted by jarring observations or alternative voices or perspectives. The critical analysis proceeded through the many questions that were generated from reading the pairs of texts ‘against each other’ (Denshire, 2014). For example, in relation to the first layered account: what role did the institutional cultures, within which I was working and writing, play in my production of the text ‘GER assignment’? And, more generally, what role do the institutional cultures of health services and academia play in restricting forms of knowledge and the voices of participants or service users, through privileging certain types of knowledge and written representations of it? What potential for learning do we lose, as professionals and academics, if our prevailing forms of texts exclude so much valuable experience? How might we be able to change this to bring a richer representation of the experiences of practitioners and participants to the fore? And how might this impact on or
contribute to transformative education in gerontology? Each of the layered accounts evoke rich descriptions of my practice, invoke analysis of the health and academic professional cultures and provoke alternative and transgressive representations of academic experience that opens up many important issues of relevance to my research question.

Conclusion

The methodology of autoethnography is appropriate to examining my research question and a specific version of the layered accounts method, as described above, was proposed as the means to carry out this project. In this method, the data and analysis are inter-twined in that the original texts form the initial data however, the untold tales constitute both part of an initial analysis (of what is missing in the original) and the data for further analysis. In this method there are both layers of data and layers of analysis, weaving between critical reflection on the personal and critical analysis of the social contexts that create a rich and complex picture of the field of study. In the ensuing chapters, the organisational and professional contexts are elaborated against which I give voice to the worlds of those I am seeking to support and to my own experiences of seeking transformative gerontology education.
CHAPTER FOUR: SPEAKING THEIR WORLD

Introduction

In this chapter I begin to focus my autoethnographic gaze on a period of great growth in my professional practice prior to becoming an academic. At this time I was a health promotion worker with older people running a mental health promotion program called Healthy & Wise. The significance of this work for me was profound. This layered account examines untold stories of my experiences and learning within the program and seeks to also represent the experiences of participants within a particular session of the program. This enables me to explore my motivation for entering academia, my expectations of the academic role and the professional practice knowledge I could bring to teaching gerontology. It also provides a vehicle for considering how these experiences might inform my current role as a gerontology educator seeking to participate in transformative education experiences with my students.

Discussing her research, Granger (2011) describes the autoethnographic process as examining

….kernels of lived experience that have become the empirical jumping-off points for this auto-ethnographic study. My descriptions of the events and their accompanying difficulties
endeavored to articulate those silent memories, while my analyses explore and work with what the events, difficulties, memories, silences – and ultimately the speaking – evoke, provoke, resist and refuse (p. 7).

This chapter includes two ‘kernels’ of my lived experience, in the form of a tale of Healthy & Wise entitled ‘Wonderful, brave, together’, written for this thesis, and excerpts from an academic assignment written in 2006 about the planning process for this program. The layered account moves back and forward between my personal experiences and the social contexts in which these experiences occurred and my analyses, like those of Granger (2011), explore the issues that are evoked through the texts, using critical reflection as well as analysis with reference to scholarly literature. My writing in this section of the thesis includes both informal and literary styles, seeking to reveal not just the events but also the emotions and interpretations of them that, together, may offer new perspectives on my practice.

The chapter is presented in four sections that include the context, the two texts and a comparative analysis of them. First, I introduce the cultural contexts (social, geographical, organisational, professional) and genesis of my professional practice work with the Healthy & Wise Program and my studentship in gerontology at CSU. Secondly, this is followed by the first text – excerpts from my ‘GER assignment’ – a report which reflects my perceptions, at the time, of official, institutional and academic cultures. The full ‘GER assignment’ is included in Appendix 1. Thirdly, the tale ‘Wonderful, brave,
together’ is introduced before providing it in full. This tale highlights the personal and relational aspects of my experience of the group and offers an alternative perspective from which to understand the program. In the final section, my ‘GER assignment’ and ‘Wonderful, brave, together’ are analysed in dialogue with each other and my learning from this process is identified in relation to the institutional setting, the client group of older people, and myself as a professional practitioner. Implications for my development as an academic in the practice of gerontology education are identified against the notion of transformative learning.

Healthy & Wise in cultural context

The Aged Psychiatry Service (APS) of north-east Victoria (now known as Older Person’s Mental Health Services and part of Albury/Wodonga Health) provides community based assessment, treatment, education and support for older people and their carers (professional and family) with mental health conditions, including depression, and/or experiencing dementia with associated social or behavioural issues. The service, in 1998, was staffed by a manager, psycho-geriatrician, psychiatric nurses, and myself as health promotion project worker, and aimed to provide a broad bio-psycho-social perspective throughout its assessment and treatment recommendations and services. In keeping with the structure of mental health services in Victoria, however, the predominant paradigm of the service is bio-medical and the main target group is those diagnosed with serious mental illness. In contrast to this paradigm, the Healthy
& Wise program was initiated in 1997 by the manager of APS, as a pilot small-group program aimed at risk prevention of depression in older people. I was appointed in 1998 for a twelve month position as the project worker to research, develop and implement this program.

When I took up this position I was both excited and somewhat daunted. I thought it was an interesting idea to run a health and wellbeing program for older people that would tackle the hard issues of grief, loss, and depression in an attempt to prepare people for potential difficulties of ageing and support their resilience. I knew, however, that the task of creating a health promotion program focusing on ageing and depression, which would attract and engage the target group of community living older people, was not going to be easy; neither ageing nor depression being readily marketable or attractive commodities in our youth focused society. Rather, ageism was and still is, widespread in the community (Angus & Reeve, 2006; Ryan, 2012) and depression was still a highly stigmatised condition not easily talked about in public or even in general health forums. Australia’s national depression awareness initiative, beyondblue, was still two years away from being established (in May 2000). Accordingly, I commenced a process of wide consultation with older peoples’ organisations and health workers in aged services within the community, aimed at both understanding and raising the level of awareness of depression in older people in the community and seeking views on how to address these issues via a small group program. The advice of some health workers was instructive, revealing ageist stereotypes in their
suggestions about what older people might be interested in as life issues (establishing gardens in small units; when to call an ambulance, for example) and what older people could cope with in a group program (two hours would be too long for people to concentrate, they would not attend a series of consecutive sessions). Older people’s organisations showed a lack of awareness, but an interest in learning about depression while individual members readily talked to me about their own experiences of grief, loss and/or depression over a cuppa. From this level of consultation I was able to recruit thirteen older people for in-depth interviews on their perceptions of health and wellbeing and the factors which they believed to support or challenge their wellbeing. This group of people became ‘peer mentors’ to the program and my analysis of the interview transcripts informed the range of topics, the language and the structure of the program, while the interactions with the mentors powerfully changed my understanding of partnering with older people in health practice. The program emerged as an eight session, two hour discussion group covering a range of topics of health and wellbeing within a ‘four-way fitness’ framework of physical, mental, social and ‘purpose’ or spiritual fitness (see Appendix 2 for program topics). I ran the first Healthy & Wise pilot programs in 1998, as a series of eight week small group discussion programs. These original programs were independently evaluated in the first two years of operation and found to be successful in reducing symptoms of depression and increasing wellbeing in participants (Gattuso, 1999, 2000) (see Appendix 3 for summary of evaluation findings, Phase 1). Based on the evidence of the evaluation, the manager was able to obtain further funding on an annual basis for this program, despite it
being outside the sector’s standard funding models and treatment programs for the seriously mentally ill. Funding was eventually built into the APS recurrent budget at a local level, however, the value of the program has still not been recognised at broader levels of decision-making on services. The Healthy & Wise program has clearly resonated with many older people in communities across north-east Victoria given that the program is still attracting full groups of participants in 2014.

Healthy & Wise challenged, stimulated and inspired me. I had never before been so immersed in mind, body and spirit in a work project. I enjoyed it and it mattered to me deeply. Each night before the start of a new program I would lie awake in bed wondering how the new group would go, and worrying. Who were the new participants, would I be able to connect with them all, how would they mesh in the group, what could go wrong and, most critically, would I be up to facilitating the group effectively? In time, I developed guided imagery rituals (like mentally packing my concerns in an old brief case and taking them downstairs, out of the house and leaving them at the foot of the ‘Bee Tree’ in my backyard!). Sleep would then come. I introduced similar guided imagery techniques in the group session on managing stress. In time, also, my experience with the program and my confidence grew and I no longer ‘ran out’ to the Bee Tree on dark nights.

During my work with Healthy & Wise I was also studying gerontology. ‘Ageing Bodies, Ageing Minds’ is a subject within the course that focuses on
health and ageing from bio-psycho-social perspectives and includes topics such as age related health issues, diversity of ageing experiences, social constructions of health and ageing and health promotion. The subject is informed by the social model of health. One assignment topic focused on planning a health promotion program and I was able to document and reflect on my experience with Healthy & Wise. At the time of studying this subject I had worked with Healthy & Wise for eight years and was also employed on a part-time sessional contract teaching gerontology subjects to undergraduate students in the School of Community Health (SoCH) at CSU. I enjoyed the formal teaching in an area to which I was so committed and wanted to do more. I was therefore, somewhat unusually, concurrently, inhabiting the roles of student, professional practitioner and new academic.

**An organisational account: GER assignment**

The first layer of my account of the Healthy & Wise program is comprised of the ‘GER assignment’ text (Appendix 1). The introduction and conclusion excerpts below outline its content, writing style and the approach to the material taken in this document, which is largely provider-centric.
Healthy and Wise: the process of planning a mental health promotion program

“Health promotion is a developing ‘art-science’ involving processes of individual, social and environmental change as well as health sciences content.” (Egger, Spark and Donovan, 2005)

Introduction

This article will document, from the perspective of the project worker, the process of development of the Healthy and Wise Program in 1998. Healthy and Wise is a health promotion program aimed at reducing the risk of depression for older adult participants.

It begins by briefly outlining the program and its history. The concept of ‘wellness’ will be examined and the working definition of health promotion used in the project outlined. The rationale for addressing the issue of older age depression through this health promotion activity will be explained, using evidence from the literature and research on the value of health promotion strategies in building wellness.

This paper will provide a case example of the ‘developing art-science’ of health promotion referred to in the opening quotation as, in the absence of similar programs for guidance, I found myself enacting an idiosyncratic model of
planning for health promotion. The process was informed by practice models from fields other than health promotion, including adult education, group dynamics, community development, action research and narrative approaches.

The Healthy and Wise program targets individual change through health education and personal support while the development phase also aimed to effect community education and awareness of the issue of depression and promotion of positive mental health in older people.

Conclusion

In this paper I have attempted to document a particular process of planning a health promotion activity related to depression in older adults. It is both the record of an actual process, using contemporaneous notes for validity, and also a commentary on the process, using current literature and perspective.

While the program itself was evaluated and the findings indicated that it was successful in improving the participants’ health and wellbeing, the project process was recorded but not evaluated in any coherent form. I believe that there is much merit in examining processes as well as outcomes in order to learn as much as we can about how to plan and implement successful health promotion programs.
The Healthy and Wise Program outcomes are indicative of the value of using health promotion approaches to reduce the risk of depression and to build wellbeing in older people. I am confident that further development of the “art-science” of health promotion will offer increased benefits for positive aging.

In the assignment, I present Healthy & Wise very conventionally, as a successful health education program, with a major focus on individual change and empowerment, and a consultative development process which included the building of community awareness, in keeping with the prevailing health promotion focus on structural, policy and community wide changes to support health, as explicated by the Ottawa Charter for Health Promotion (World Health Organisation, 1986). I reveal my sensitivities about the criticisms of health promotion based on individual change, arguing that there is a place for individual health education in health promotion and that this is an example of a program which has achieved improved mental health and wellbeing for participants, as evidenced by independent evaluation. Despite making claims of the value of examining processes as well as outcomes of a program and noting an ‘idiosyncratic’ planning process, I did not offer any examination of the particularity of the process. The assignment can be seen as largely a celebratory account that glosses over the nuances and tensions of the lived experience of the program and reveals nothing of the mentors and participants or the way in which the program worked in practice.
The untold story: ‘Wonderful, brave, together’

In contrast to the ‘GER assignment’, ‘Wonderful, brave, together’ is an intimate tale of an experience of Healthy & Wise Women through my eyes, which is not found in any of the other documentation of the program. The tale opens up for discussion important issues such as the resilience, agency and meaning-making of participants, which challenge provider centric and ageist assumptions about health care with older people. It also highlights professional practice issues such as the facilitator role in group programs, the importance of relationships in the process, issues of ethics and safety within group practice and, exemplifies the interweaving of different professional practice elements, described by Titchen & Higgs (2001), as propositional, professional craft and personal knowledge, by Barnett & Coate (2005) as knowing, acting, being and by Hutchings (2010), as head, hand and heart knowledge (and corresponding somewhat with the Frenk, et al. (2010) schema of informative, formative and transformative education). The tale suggests that relational and ‘co-production’ elements of the program may be implicated in its success.

‘Wonderful, brave, together’ pivots around several moments of risk, courage and ultimately growth, which occurred one day in a group session of a Healthy and Wise program somewhere within the north-east of Victoria in the early 2000’s. Many such fraught moments arose over the years within the groups, when vulnerability was revealed and conflicting views raised tensions. These were resolved either by my contributions as facilitator or by contributions of
other members of the group. This tale represents my memory of a particular occasion; however it is also a distillation of my feelings and experiences associated with many such moments. The characters in this tale, who I have named Edie, Stella, Amelia and Marion, are based on real women and also represent many others.

**Wonderful, brave, together**

It’s a big, newly renovated room, full of light from a wall of windows looking out over lawns to the road. Cupboards contain all the crockery, cutlery, dishes and trays to collect and convey a hearty and luscious afternoon tea. Utilitarian white dishes spill over with cheese and crackers and fruit, to honour the health focus, and home-made cakes, of course.

Clean and fresh, but bland when empty, the big space fills with the rapidity and promptness of a cohort which values punctuality and responsibility. Colour, noise and movement flow in and around the room carrying a palpable warmth that comes from these older women connecting with each other, drawing each other in to the current of talk and laughter, checking on each other - “are you well?”, “how are the grandkids?”, “how is your garden surviving?”, “good to see you!”

It seems a light-hearted gathering. However, soon I will raise my voice in a formal welcome and we will get down to our business. There are twelve of us in the room today, the entire group is here, plus me, as facilitator, and a local
health worker, who oozes warmth and bakes stupendously. These ten diverse older women from a smallish rural town in North-East Victoria have responded to articles and advertisements in the local paper, flyers and word of mouth, to join this local incarnation of the Healthy and Wise Women Program. They have answered an invitation to talk about getting the most out of life as they get older and to share what they know about this. Three sessions of discussion, laughter, health talk and gentle exercises have already warmed and nourished us as a group. We have adopted a motto about ageing - ‘consider the worst and celebrate the best.’

Today is the fourth of eight sessions and we are talking about depression. What is it? How is it any different from being sad, feeling grief, being lonely or worrying a lot? How does it make us feel? What things have triggered our sadness? When do such feelings become depression? How do others view depression? Why does there seem to be a stigma associated with what is, after all, a common human experience? What treatments are there? What assists recovery?

After our welcome, I talk a little about what we mental health professionals understand about depression, setting the scene with carefully crafted words offering, I hope, clarity and optimism. Some of the women have been touched by depression. All have known sadness and grief. It is important that I am able to offer a context for their experiences, the reassurance of professional knowledge, and yet not allow the medical aspects of the information to
overwhelm the life experiences which I encourage them to bring to our shared understanding of this issue. It’s a fine balance.

A vast accumulation of loss, grief, sadness and worry is gradually released into the light-filled room as various women take turns joining in the discussion. Edie speaks up early in the conversation about her experience of depression.

Edie had come to the first group meeting tentatively and had seemed instantly identifiable as someone vulnerable. It seemed, that first time, as if her hands were in tight fists, screwing up courage for the effort of walking into the room and of holding herself there. Edie’s courage in speaking now is palpable and bestows on her a fragile dignity which I don’t think she realises. Edie’s sadness has a length and breadth which stretches across the Nullarbor, from the east coast, to the West and back again. She has moved frequently in her lifetime, clean across Australia, and some of these moves have caused fractures. She has become estranged from members of family, from homes she has made and loved, from safe places in her world. The recent death of her partner has left her bereft of security and nourishment, lonely and almost bewildered as to how her life has come to this. She is a woman alone, craving domesticity and missing the opportunity to love and give within the bounds of hearth and neighbourhood. We are moved by her openness and saddened by the sense of emptiness she has described. The other women soothe her distress and she seems replenished somewhat by their care.
Edie has opened up the discussion to a more intimate level and the sharing continues.

Some women speak hesitantly, their words faltering before regaining strength to continue, others speak in a rush, words tumbling out in a need to be spoken, to be released, perhaps, from the pain and loneliness of silence. Long-time silences. Almost life-time silences for some.

There are silver and grey and freshly coloured heads nodding in recognition, murmurs of assent and points of difference within the landscape of inclusion, of shared experience, and I think that I can detect a faint but growing sense of relief. A growing sense that “Maybe it’s not just me who feels like this”. A somewhat ordinary thought, but one which can be dizzying in its magnitude, quietly reshaping lives on this sedate country town afternoon.

Not everyone has experienced or witnessed depression. A few voices are quizzical, perplexed, hearing, but not quite understanding, straining to relate to what is being talked of by others. I feel there may be sturdy words like “pulling up socks” and “getting on with it” hovering on the tips of a tongue or two, and then Stella spills them out.

Stella bridles at the idea of depression; she is brisk, matter of fact, salt of the earth and capable as a farm woman can be. She is clear and strong, her tone habitually authoritative. Her personal template of capability covers the notion
of depression with impatience and obscures for her the nub of experiences of those who have just spoken of it. As she enunciates the room goes still and quiet for a beat or two. There is fragility in the act of sharing such personal experiences as those women have done and I see that this is a moment of great vulnerability. A pit has suddenly opened up in the room and I hold my breath. In the silence, I think others are holding also. We are waiting to see if the pit will engulf us. Or can we avert the yawning black mouth of discomfort and distress that all of a sudden threatens to overtake us? We are witnessing that pain, so bravely shared, seems suddenly exposed to Stella’s judgement, stoutly spoken. Although echoing community attitudes that have kept these women silent for so long, Stella is not uncaring but unaware. I feel for those who have shared their troubles and fear that their relief, still tentative, may flee and shrivel in the face of this challenge. I hesitate for a few more heartbeats and then draw in my breath and open my mouth to speak, not knowing exactly what I am going to say, seeking words to bridge the chasm, words to honour Stella’s contribution, yet affirm the validity of the issues described by others. Seeking a safe path forward, intending to secure the fragile hope for those who have shared their vulnerability. Before I can speak, however, Stella’s friend Amelia, says “But Stell, do you remember how Bee was that time?” and she goes on to detail a few events of their shared history with a loved friend, events in which many of us begin to recognise a similar pain to that already described within the group. As Amelia talks, I feel like the room begins to breathe again. I almost hear a gentle collective sigh, almost feel a tangible release of pressure. Some women relax a little in their seats, settling back amidst a collective relief.
And the look on Stella’s face is arresting: she seems frozen for a second or two, listening with distant eyes. Processing Amelia’s words? Searching her memories? A wave of acknowledgement washes over her face. It is as if something has changed, an elastic band pulled tight has snapped and a softening and easing is apparent in her features. “Yes.....” she says slowly and almost wonderingly, the briskness now vanished, “yes...... I see what you mean...I’d never thought about it like that.”

Amelia’s anecdote and Stella’s epiphany have changed the terrain, it is clear that a bridge will no longer be needed. Together, they have drawn the exposed sides of the gap together, closed the chasm. We are back on terra firma, listening and learning. Experiences shared have been recognised and, in so doing, all of the women are again feeling strengthened and validated.

Marion is a tiny, straight-backed woman, with a steely gaze and immaculate silver hair. She is well-respected in the community, her efficiency, organisation, intelligence and capability recognised around town due to her previous high-profile profession. She was prominent in the first session, almost critical I felt, questioning the ‘house-keeping’ arrangements for the group, impatient, almost abrupt. I had wondered then if she perhaps thought the meandering “getting to know you” icebreaker discussion and the seeking of participants input into the groups own ‘safety rules of engagement’ was somehow ‘fluffy’ or time-wasting? Marion maintains the air of someone who doesn’t suffer fools and can’t abide wasting time. She had indicated that she was here in the group to
learn and seemed keen to be presented with educational content. (I had wondered ruefully if she might perhaps relish an exam?). I had been a little intimidated by the apparent challenge of meeting her particular expectations while aiming to help her also value and participate in the group process. I had hoped that she would come back for the second session but anticipated that she might not. I had felt regretfully unsure that I had, in that first session, managed to engage her.

As it happened, Marion had returned the next week, said little, but appeared to be listening with interest. She continued to attend, quietly, flying below the radar.

Marion’s posture during this discussion of depression was rigid and as Stella first spoke her face flushed slightly. She held herself still and silent. In the buzz of relief after the penny dropped for Stella with regards to her friend Bee’s experience, Marion surprises us by suddenly revealing to the group her own long-standing depression, the experience of which has been devastating for a woman of her expressed high standards for capability and common-sense. She has castigated herself bitterly for her “weakness” and “incapacity to control” her life. She has railed against her GP and others around her in her attempts to avoid the diagnosis. She has been steadfast and powerful in her refusal to seek help or acknowledge her needs. It seems that she has been frightened and at risk of harm.
Marion’s story is told with an urgency and directness which is compelling and stark. Her pain and shame and not-yet spent anger, self-directed, pounds into the room. It is a live force, released at last. In release, its hold on Marion faces imminent defeat but the feelings are still turbulent and hold seeds of danger. The group absorbs this force and allows it to gently disperse, generates acceptance and warmth to take its place.

Afterwards, Marion seems drained. Her posture is now less rigid but her complexion still ruddy. I hope that the immediate relief of finally being able to acknowledge her depression, together with the support offered by the group, will be sustaining and that it will not be overtaken by the regret of a fiercely private woman who may fear that she has said too much or shared too publicly. This disclosure is simultaneously a wonderful lurch toward healing and the courageous taking of a risk which can sometimes, immediately afterward, feel calamitous. I am concerned for her at this time of vulnerability.

The discussion continues. Voices soar in an intense weaving of harmonies, cocooned gently within the group’s developing consciousness of its own distinct weight and shape. The group has become a refuge, a respite, a neon-lit welcome, a place outside of the everyday afternoon, where despair may just possibly be parked for a while, where tears can flow and pain may ease its grip, where new possibilities arise and laughter flows despite all. This is the power of connecting with others who hear and acknowledge.
I call Marion after the session to check in on her and am reassured that she will be safe, however she doesn’t attend the following session a week later and I am, again, concerned for her wellbeing. She calls me the next day to say that she has finally taken action on her depression and has been in the city for a few days for treatment, causing her to miss the group. She asks about follow-up psychiatric services in the community, of which she is aware but has always, so far, refused to consider. I encourage her to give them a try.

Marion assures me that she will contact the recommended services and will be back at the group the next week. She is adamant that the group has freed her to finally recognise and act on her situation. It seems to me that, in listening to others share their experiences, she has, at last, been able to accept herself.

I hang up the phone with a huge sigh of relief. I should feel jubilant that the group has worked so well for Marion, maybe I will later, but right now my knees feel shaky. I press them down hard against my seat and sit very still. It has been brought home to me, once again, how much this work matters and how much of a tightrope it can be. I am grateful that our safety net, woven of the people and processes of the group, has caught and supported Marion and Edie securely whilst they regain their strength to move on.

I marvel, again, at what happens when people are given the opportunity to talk about the things which matter deeply to them. At what happens when they listen and speak and are heard respectfully. This is important meaning-making work
and sometimes scary. I take another deep breath and continue on with my paper-work.

Weeks later, at the end of the final session, the inevitable participant evaluation sheets are proffered and completed.

A few days later again, back in my chronically untidy office elsewhere in the north-east, I read the evaluation sheets. Amongst the items is one question which asks the women to choose three words to describe the program.

One woman’s response just nails it for me........ “wonderful, brave, together”!

Critical reflection

During the period of my work with Healthy & Wise, I recall being able to speak quite articulately in informal settings about my reflections on the program, suggesting a multiplicity of practice understandings. However, it seems from my assignment that I saw no acceptable professional or academic language with which to define or discuss my observations and ideas as another form of knowledge about practice worth writing about. So my representations of practice knowledge, together with the participants and mentors experiences, were, in effect, silenced behind the propositional knowledge and quantitative evaluation data that are conventionally privileged in health and academic settings. Labonte paraphrases the great educator, Paulo Freire, who claimed:
the first act of power people can take in managing their own lives is ‘speaking the world,’ naming their experiences in their own words under conditions where their stories are listened to and respected by others (cited in 2007, p. 12)

This analysis examines an instance of older women striving to speak their world in unfavourable social circumstances, and the challenges this presents for gerontology health practitioners whose role it is to facilitate the respectful and attentive conditions they require in order to do so. I begin with the institutional contexts that shape professional practice in gerontological services before examining what they mean for older women as active agents in their own health and my learning and role as facilitator. Finally, I note key questions and perspectives that have been identified through this practice and examine these in relation to the social transformation imperative (Frenk, et al., 2010; WHO, 1986) of gerontology education.

*The power of institutional and professional cultures*

In my GER assignment it seems that I was unable to speak fully of my practice. A range of institutional factors stifled my voice and, by extension, participants’ voices about the truly transformative elements of the Healthy & Wise program. It is argued below that these included the celebratory and positivist reporting needed to secure funding and the dominant theoretical and knowledge paradigms that continue to prevail in health and academic sectors. These forces support a form of institutional ageism that denies the capacities and rights of
older people by silencing their perspectives. Ageism acts to blur the person and turn her/him into a stereotype, a generic and undistinguished member of the group labelled old, no longer seen as an individual (Butler, 1975). Some older people accept and internalise such ageist stereotypes, thus feeling not only invisible but also accepting the limitations attributed to them and the inequities foisted upon them (Cruikshank, 2003).

The ‘GER assignment’ can be seen as a ‘celebratory account’ (Groundwater-Smith & Mockler, 2007) of what happened in planning and running the program. A celebratory account is a version of an event, where the problems, difficulties and uncertainties have been written out of the process, leaving a constructed outcome which represents achievement or success as easy and untroubled. Unacknowledged challenges in planning this program included the mixed responses of local health workers, some of whom were sceptical of the potential for this program, largely due to ageist assumptions of what older people might be interested in and capable of. There is no indication in the assignment of this, or of the trial and error and challenges of learning to use authentic, simple and relevant language and ideas in promotional material to engage people with the idea of participating in a project around ageing and mental health. Formal organisational documents are often written as celebratory accounts thus showing the event (or process or program) in a positive light, thereby excluding the potential for learning from the unacknowledged challenges.
This impulse reflects deeper assumptions about acceptable and legitimate modes of professional practice. Titchen & Higgs (2001) note that health professions generally prefer predictive theories deductively derived (following the biomedical model and scientific approach to generation of knowledge) rather than “interpretive, explanatory theories inductively derived from studying health professionals’ own perspectives on their practice” (p. 219). It would have been really interesting to have examined, in the assignment, how I connected these concepts within the program planning, thus opening up my practice as a potential source of inductively derived theory. Instead, I chose to (clumsily) validate my planning practice by attempting to make it fit Galbally’s integrated model of health promotion, which includes: identification of need of sub-group; matching sub-group to appropriate program model and methodology; recognition of key settings for organisational change; and evaluation (cited in O'Connor-Fleming & Parker, 2001). While the overall planning process of Healthy & Wise reflected these general steps, the breadth of models such as this left me looking for more detailed guidance in undertaking steps such as the ‘matching sub-group to appropriate program model’, as I could not find a program model used with older people on which to base the program. Hence, various ‘eclectic’ influences helped to shape the process of building our own model of practice and program. However, even though, as I state in the assignment, I had not actually used the Galbally model significantly in my planning, it seems that I have still attempted to line up the complexity and “idiosyncrasies” of the planning process I had actually undertaken in the “messy world” (Muncey, 2010, p. 28) of real practice with
what I saw as more credible established theory. Selby (2005, p. 8) argues that the social and organisational contexts of academia, such as the high status afforded positivist and quantitative evidence, act on academics in ways that encourage them to “dress up their work in ill-fitting theoretical clothes.” Similarly, as a practitioner and student, I felt the need to ‘dress up’ my discussion of the program planning process with theory in order to provide external validation for my practice experiences rather than simply acknowledge, and usefully examine, the actual process which I had used.

My practice in Healthy & Wise was undertaken within the generative context of a local mental health service that endorsed the social model of health, however was largely required to operate under state-based guidelines emphasising the priority to serve those with serious mental illness and within a culture that primarily valued medical treatment of mental illness via medication (Powell, 2006). In contrast, my professional practice as a social worker led me to prioritise the social aspects of health and relational ‘treatment’ in addition to possessing a sound knowledge of depression and mental health from the biomedical perspective. Within my organization the Healthy & Wise program was strongly supported by the manager, however, we struggled to gain wider support for the program at state policy levels as constituting ‘real’ mental health work. Despite the support and autonomy given to me by my manager in developing and running the program, I was conscious of a need to justify myself, the program and the participants in the face of biomedical dominance of mental health policy and understandings of evidence-based practice. For
example, funding submissions required focus on the quantitative and biomedical measures of the evaluation, specifically the Geriatric Depression Scale (GDS) scale, to gain attention from funding sources focused on a narrow interpretation of evidence. It seems likely then that my ‘GER assignment’ reflected my assumptions and internalisation of both this health professional and academic organisational culture about knowledge and its formal representations in writing. In the ‘GER assignment’ I used a conventional style of writing in a report format, seeking to convey objectivity through the use of third person voice and invoked quantitative research data, theoretical, biomedical and social literature on ageing, mental health and health promotion to support my description of the planning process which I had undertaken. This is a reasonable, useful and well accepted approach. However, in so doing, I validated the program solely according to prevailing organisational and academic cultural standards, which privilege positivist, scientific, technical, theoretical, (ie. propositional or informative) knowledge over other forms of professional knowledge (Titchen & Higgs, 2001, p. 215) and negated other aspects of the participants and my own experience of the program.

Interestingly, in yielding to the “dominance and authority” (Smith, 2005, p. 27) of positivist knowledge, I also failed to honour and explore the contention of my opening quote in the assignment, that “health promotion is a developing ‘art-science’ involving processes of individual, social and environmental change as well as health sciences content” (Egger, Spark, & Donovan, 2005). I recall having chosen to open with this quote because I was attracted to the idea
of ‘art’, or artistry, having a place alongside health science in the spectrum of health promotion. This resonated with my personal practice observations, and, much later, the substance of ‘Wonderful, brave, together’, that less scientifically measurable factors, such as the personal skills and creativity of the workers and the relationships formed with participants, the attitudes, and willingness of participants to share personal experiences, were significant factors in the success of the program. However, I did not discuss any of these factors or any other evidence of ‘art’ playing a role in the program planning. Again, I did not have acceptable professional language available through which to pursue this highly relevant concept of the place of artistry alongside science in health promotion practice. As Muncey (2010, p. 28) argues, “in our attempts to achieve internal validity in research at the expense of ecological validity, the complexity of individual experiences gets lost in the wash.” My representation, in the ‘GER assignment’, of solely propositional knowledge and writing out of the other forms of professional knowledge which inform and define health practice and make visible the individual, interpersonal and situational elements of practice, therefore, conforms to a strong and widespread tradition of research myth-making (Grinnell, 2011, p. 4).

The dominance of propositional (and biomedical) knowledge and positivist research in health and academic institutions holds great significance for gerontology education. Where these elements interact with ageism they further silence the voices and experiences of older people and narrow the parameters of what we choose to investigate and therefore what we ultimately understand
about health and ageing and how to practice effectively with older people. Powell (2006) argues that in western societies, knowledge of ageing has been socially constructed within “powerful, taken-for-granted assumptions” (p. 1) that privilege bio-medical disciplines and sustain the legitimacy of political and economic discourses that frame, and the primacy of professional experts that enact, bio-medical imperatives. While ageing includes ultimate physiological decline, and biomedical perspectives are essential for managing and treating medical problems, “totalizing views of biomedical science” have ensured that ageing can hardly be imagined otherwise (p. 6). The ensuing “biomedical problematization of ageing” has obscured the impact of broader social issues of power, inequality and culture on ageing (p. 8).

My assignment description of the Healthy & Wise program reflects this aspect of professional culture, by including the perspectives of the mental health agency, the professional (myself), the independent evaluator, together with theoretical literature, but not the perspectives of participants. Lee and Dunston (2010, p. 61) note that traditional conceptions of professional practice tend to be “provider-centric”, whereby policies, purposes, structures, methods of practice and organisational documents reflect and serve the knowledge and interests of professionals and organisations to a greater extent than those of the patients/consumers/participants they are intended to serve. In this way, I unintentionally acted to compound the ageist attitudes prevalent in our community (Angus & Reeve, 2006; Ryan, 2012), and within health services and amongst health workers (Eymard & Douglas, 2012), which obscure the
personhood and individuality and agency of older people. Acknowledging this point now is shocking to me, as I had believed that I had always enacted anti-ageist attitudes in my practice and contributed to a public advocacy of older people as active citizens, irrespective of age. Yet, a comment from an anonymous focus group member in the first evaluation report suggests that in practice the program differed from the ageist provider-centrism she normally encountered:

I didn’t feel invisible there [in the Healthy & Wise group] like I do everywhere else (cited in Gattuso, 1999).

While clearly not the experience of all older women, this is a feeling I have heard expressed by many women and this statement is evidence of a personal experience which enables us to connect with and examine a broader social context, in this case the ageist attitudes which minimize the personhood of older people, in particular, older women (Cruikshank, 2003).

Under the developing socio-political discourse of neoliberalism and associated managerialism, whereby the focus is on older people as consumers bearing individual responsibility for their health and status in society, there has been a movement away from the ‘helping relationship’ to ‘care (or case) management’ concepts (Powell, 2006) that focus on managing scarce resources as much as providing care for identified needs. The disconnect between what I felt I had to convey to funders and policy makers about the program and the lived experience of it by the participants and I, speaks to subconscious decisions I was making about the strategies needed to provide respectful and safe
conditions for older people to be heard within the dominant dehumanising culture in which we were co-located. My experiences raise questions about what sort of knowledge is required for practice in gerontology that can critique and challenge the contemporary socio-political culture of neoliberalism and provide conditions that support older people? However, the call of Frenk et al. (2010) for this kind of transformative education has not yet been explicitly taken up in gerontology education.

These aims can be seen to fit within the realms of critical gerontology, which is concerned with “identifying possibilities for emancipatory social change, including positive ideals for the last stage of life” (Moody in Wild, Wiles, & Allen, 2013, p. 137), although this literature has yet to substantially impact the gerontology education field. Amongst the key areas in which emancipatory social change is required are in freeing gerontology practice from the dominance of biomedical, propositional and positivist cultures of knowledge and opening it up to a more expansive range of interdisciplinary, practice based and interpersonal knowledge, grounded in values and ethics of social justice and reciprocity of relationships. There is surprisingly little gerontology education literature that enquires into the forms of knowledge required by gerontology practitioners to work effectively within current or developing health contexts or the ways in which this critical knowledge may be taught. A focus on propositional knowledge dominates due to cultures of both professional practice and academia placing “more emphasis on the application of theory to practice than on the integration of these three forms of knowledge”
Frenk, et al. (2010) report, from their global study, that one of the major problems of health professional education is a “narrow, technical focus without broader contextual understanding” (p. 1923), again reflecting the dominance of propositional knowledge and its power to shape and limit informative education. Other problems concern formative education such as the siloing of professions and lack of interdisciplinary teamwork competencies, gender stratification of professional status and “weak leadership to improve health-system performance” (Frenk, et al., 2010, p. 1932). Given that transformative learning occurs within personalised, creative, collaborative and empowering contexts (Hutchings, 2010) it is significant that the dominant biomedical and propositional representations of practice and informative education available to practitioners, educators and students tend to exclude these elements and the dominant formative education of technical professionals adds to this narrowing and segmentation of practice. Angus (2009) usefully identifies leadership as a key construct for gerontology educators in developing curriculum for dementia care practitioners and argues that this is a broader concept than simply being associated with management tasks that sustain aged care within the neoliberal culture of individual responsibility, consumer ‘choice’ and market forces. Her work invokes the centrality of transformative professional relationships with older people that assist in providing conditions within which they can speak their world and it is to this that I now turn.
Re-reading my ‘GER assignment’ for the first time in years was a discomforting experience because I was shocked to realise how completely I had written out many significant people and processes from this text - the mentors and participants with whom I interacted and whose roles were so important to the development and outcomes of the program are barely represented at all. ‘Wonderful, brave, together’ shows the mutually supportive connections between participants and between myself and participants. It underscores how older people refuse to be silenced by objectifying institutions and ageism, using the Healthy & Wise program in their own ways and refusing to privilege professional expertise over their subjective lived experiences.

‘Wonderful, brave, together’ focuses on moments of vulnerability and challenge in the group when things could have gone wrong and shows the difficulties and complexities of group practice alongside celebrating the positive outcomes on this occasion. Although highlighting a ‘successful’ outcome of the session, this text shows some of the bumps and uncertainties along the way and that responsibility for the outcomes is necessarily shared between worker and participants. It enables the facilitator to be revealed as fallible and take a back seat to participants. I also comment, in the GER assignment, about my ‘idiosyncratic’ process of planning and an eclectic range of theoretical approaches which had consciously informed my practice in developing the program, however this is not explored. In it I state:
The methodologies which I used to guide my planning for this program included participatory action research techniques (Stringer, 1996), which informed my community consultation process and ensured a reflexive process; narrative techniques which informed my exploration of the expert knowledge held by people authoring their own stories of wellbeing; and adult education approaches.

White’s (2007) narrative concepts of people ‘re-authoring’ their own lives and of the mutuality of relationships, with the therapist ‘giving back’ to the client feedback on what she was learning from the client particularly informed my practice in exploring experiences of wellbeing with the mentors. By inviting learning from unanticipated outcomes and even mistakes and potential errors of professional judgment, this narrative approach sat awkwardly within the institutional pressure for celebratory accounts of flawless professional practice.

‘Wonderful, brave, together’ also goes against the prevailing culture of objective science to deal with the personal, the relational and the direct experiences of a professional practitioner. This text brings a particular group of participants into view and is a highly unusual text for academic or professional purposes and yet reveals things about the program that are important and have previously gone unrecognised, even by me as the facilitator and writer. This explicates the nature of professional craft knowledge and personal knowledge in practice. For example, being able to create a safe group environment for sharing sensitive or confronting discussions, like that on depression, is
grounded in experience and professional craft/acting/hand knowledge (as taught in formative education) about working with other groups of older participants, built on a base of theoretical (propositional/knowing/head) knowledge (informative education) about group dynamics, while utilising my personal capacity to engage with people in service of the particular relationships helpful to group process reflects personal/being/heart knowledge and through integrating each of these levels created a transformative educational experience for me. My experience of running many Healthy & Wise groups led me to expect that, contrary to the assumptions of some community and health workers initially consulted, participants would be not just willing, but eager to discuss the difficult issues facing them in ageing and I had developed skills in creating a group environment that would support such discussion in safety. Each of these forms of knowledge was being used, in practice, in integration with propositional knowledge, in this case established bio-medical understandings of depression (Ames, Chiu, Lindesay, & Shulman, 2010), understandings about the social determinants of mental health (VicHealth, 2005), and theories of group dynamics (Lindsay & Orton, 2008). To have gone against the health professional and academic cultures that privilege propositional knowledge in my assignment to show the integration of these forms of knowledge in practice would have valuably given central place to the participants’ and my own agency (Titchen & Higgs, 2001) and perhaps revealed glimpses of transformative education.
In re-reading ‘Wonderful, brave, together’ I find myself gaining a new recognition of the purpose, agency and courage of the participants. They are not just coming to the program seeking hints on health and well-being; they have come to share their experiences, to help each other and to take on the challenges of ageing. These are ‘ordinary’ women, very different in experiences, personality, resources, and starting points of wellbeing but there are no passive recipients in the room. Everyone is engaged. ‘Wonderful, brave, together’ captures the energy and agency with which the older women participants of this program made it their own. In this story the characters of Edie, Stella, Amelia and Marion are actively making their own sense of meaning around the issue of depression in later life. They are not shadowy participants in a program which is being showcased. Shown to be owning and sharing the time and space, these women are creating the program afresh through their engagement and agency. They take their lives in their hands (or in their words) and confront ageing and depression with courage, honesty, a desire to learn and a great capacity for mutual support; yet these insights are lost in the GER assignment.

In the assignment there is also only a brief mention of the recruitment of volunteer ‘mentors’ to the project where I state: “The program content was developed in consultation with community groups and through detailed interviews with older ‘mentors’ whose themes of wellness and coping with difficulties influenced the content.” This was the only mention made of the thirteen very different peer mentors, whose developmental role in the program and in my learning, as facilitator, was highly significant. For example, the
“Getting Things in Order” session was included in recognition of the concerns of several mentors about financial and legal issues that impacted on their wellbeing. The “Social Whirl” session encouraged discussion of family relationships, amongst other issues of communication and connections with friends and community. Even more importantly, the experience of interviewing the mentors, the generosity with which they shared insights into the struggles and joys of their lives and the evidence of their individual meaning making about their ageing, gave me a profound new respect for the diversity and agency of older people seeking to make the best of their ageing experience.

The relationships amongst participants and between facilitator and participants are evident in ‘Wonderful, brave, together’, as is the critical importance of this supportive relational context in enabling the women to feel safe to take personal risks of disclosure and, ultimately, to grow and develop their resilience and wellbeing. In my GER assignment, I had included criticism noted by Egger, et al. (2005, p. 1), that health education models were seen to be of limited value, compared with health promotion aimed at community development and changing relevant social determinants of health. This was a criticism that I recall feeling sensitive about during the process of planning and implementing Healthy & Wise, as the groups could be seen as health education, focusing on helping individuals to change. This focus was not favoured in the health promotion literature that advocated (on good evidence and correctly) the value of broader action for structural changes to social determinants of health and community organization and cautioned that a continuing focus on personal
change risked minimizing the structural and public responsibilities for health and change to promote health (Labonte, Woodard, Chad, & Laverack, 2002; Laverack, 2006). I countered this with reporting also on Egger et al’s (2005) contention that health education offers a potentially effective approach if based on adult education approaches in the context of peer discussion and well-managed group dynamics. Ultimately, the effectiveness (or not) of health education can depend on whether the experience for participants is empowering (Laverack, 2004).

Disrupting the objectifying positivism of the health and academic cultures in which I was located, ‘Wonderful, brave, together’ shows the personal and local through detailed characterisation and subjective reimagining of some participants. Stella and Marion leap off the page showing not just what happened, in great detail, but who the participants were and how they participated in the program and made use of the opportunities afforded by it to actively work on their health and wellbeing. The resulting tale powerfully reveals how some older women may have experienced depression and, in so doing, enriches understanding of depression as a complex and lived phenomenon. In Amelia’s intervention, for example, which re-frames the experiences of depression spoken of by others to be meaningful to her doubting friend Stella by applying them to a mutual friend’s story, there is a simple but powerful example of the way in which participants engaged actively and positively with difficult issues and with each other. It is an example of the capacity of the women to examine challenging life experiences, by creatively
weaving together the elements of health information from the facilitator with the range of experiences shared by the different women, within a context of warmth, acceptance and support for one another. This process is not smooth and comfortable. It is loaded with risk and the potential for widely differing or conflictual views of the issue. Stella’s questioning of the idea of depression was significant, not only because of her authoritative manner but because she was articulating a commonly held view in the community (that depression is in some way a character failing that one needs to just try harder and get over) that acts to silence and shame people experiencing depression. The women who had spoken of their experiences were made vulnerable to this dominant perspective, however Stella, Amelia, Edie and Marion are each seen to be actively seeking meaning and embracing, with courage, the risks and possibilities of change. In re-reading this tale it is apparent that the experiences of many of the women have something in common with transformative learning as described by Hutchings (2010). The characteristics of transformative learning spaces that she lists (personalised, creative, challenging, collaborative and empowering) can be seen in the group environment, the element of risk or a ‘disorienting dilemma’ as a catalyst for change is certainly present, and the experience of a deep shift in perspective can be seen in relation to Stella and Marion for example. Indeed, qualitative information from the initial independent evaluations (Gattuso, 1999, 2000, 2003) indicates just this outcome and feedback from many participants over the 16 years of the program continues to speak of the positive changes they have made in their lives and to use the words ‘life-changing’ that indicate a level of significance, value and scale of the changes they have made.
The evaluation outcomes noted in the GER assignment provide additional empirical evidence of the value of such an approach to health education, while ‘Wonderful, brave, together’ shows vividly how this group of older women actively engaged with the information, discussion and relational dynamics of the group to make meaning of depression and wellbeing. These are two different but complementary types of evidence of an effective health education program however, until undertaking this layered account, I had only ever articulated and relied on the empirical evidence. Labonte (2007) confirms the value of narrative in providing information on the meaning of events, rather than attempting to establish the truth, and as an enhancement, not a substitution for other forms of evidence. He also notes the “evidentiary base” that a story requires if it is to be considered as evidence - that is, a story needs to be understandable, defensible (by reference to empirical evidence or moral argument), sincere (with no intent to deceive) and, finally, it must invite response and questioning (Labonte, 2007, p. 31).

Notwithstanding exclusion of participants’ stories in my GER assignment, narrative enquiry did inform my professional practice. For example, I included a formal process of ‘giving back’ to the mentors my experience of learning from them, which I did in detail in letter form, adapting narrative techniques from White (2007). This felt like a slightly risky development in that it required me to open not just aspects of my professional knowledge to the mentors but also my ethical, reflective ‘heart’ knowledge (Hutchings, 2010), and writing
skills, as well. This process closed a ‘loop’ of mutuality in learning about wellbeing in ageing between mentor and me and powerfully influenced my expectations and interactions with participants in implementing the program. Likewise, the only reference to the participants in the assignment was oblique: “Positive group dynamics builds new social supports amongst participants.” It feels like a betrayal to have left these people out of the story provided for assessment, whereas in ‘Wonderful, brave, together’, I have fore-grounded and richly represented the older women participants of the program. ‘Wonderful, brave, together’ shows, in a snapshot of practice, some of the depth and complexities of individuals in relationship to each other and reveals a vibrant alternative picture of the Healthy & Wise program. At the time of working with the program my intention and practice was on empowering the older people I worked with to better manage the health and social challenges they were likely to face in ageing. Participants are usually the least powerful in relationships with professionals and health systems, but in keeping with my social work perspectives and the aims of the program, I attempted to use my ‘power with’ (Laverack, 2004) the participants to assist them to gain power and agency within my relationship with them, within the program and in other aspects of their lives.

In reading my GER assignment now, in conjunction with ‘Wonderful, brave, together’, it occurs to me that while the contribution of peer mentors may be correctly categorised as community consultation or research, the particular nature of the reciprocal learning relationship between the worker and
mentors/participants also holds potential for development of a process of ‘co-production’ (Lee & Dunston, 2010) of healthy ageing. The peer mentors’ contribution to the Healthy & Wise program content, format and relationships between the worker and participants has been highlighted by the process of examining this layered account. Together with the active creation of meaning and support around depression shown by the women participants in the ‘Wonderful, brave, together’ tale and the reciprocal learning evident between facilitator-as-participant and participants assisting with facilitation, this layered account suggests the potential for co-production of health education programs for older people. The potential for older people to take a stronger role in service design, implementation and evaluation of services thus suggested could be enacted by redefining the relationships between professional worker and participant from the traditional provider-centric model to a partnership and reciprocal learning model.

This, of course, requires disruption of the traditional power differential between expert professionals and their clients (Laverack, 2004) and a strong focus on empowerment of clients/participants. My writing of ‘Wonderful, brave, together’ along with a critical reading of this tale in dialogue with my GER assignment has lead me to articulate more clearly the capacity of these older women participants to play an active role in the group, co-producing their own personal growth and wellbeing and those of others. This understanding would certainly challenge the ageist views expressed by health workers in my initial consultation, whose restrictive outlooks vastly underestimated the capacity,
courage and enthusiasm of older women (and men) for engaging with health, wellbeing and self-development issues. The value of this example is in showing the potential for a different type of partnership between health professionals and older people in which each party engages in healthcare education in a reciprocal learning relationship, co-producing improvements in health and wellbeing.

*My power as practitioner*

The disjuncture between my two accounts of the Healthy & Wise program, demonstrate the ambiguities of my role as a practitioner serving two ‘clients’ whom, as noted earlier, often had conflicting priorities – the profession and institution within which I was employed on the one hand and the older people I was employed to support on the other. Clearly, my efforts to secure funding by conforming to the former’s reporting expectations were driven by my personal and professional goals to support older people. This analysis offers insights into the invidious position that many practitioners find themselves as employees of objectifying and sometimes oppressive social institutions. Important preconditions for health practitioners meeting Frenk et al.’s (2010) rally cry are self-awareness of professional power and strategies for keeping faith with personal and social justice goals where they run up against institutional and professional cultures. In this section I critically reflect on my compromised position and elements of gerontology education that can assist practitioners develop transformative relationships with older people.
In ‘Wonderful, brave, together’ I have portrayed the individuality of Edie, Stella, Amelia and Marion as I was privileged to get to know them and, in so doing, hopefully acted to counter the ageist stereotypes which may elsewhere render them invisible, including in my ‘GER assignment’. While the assignment required a strict word limit and the topic focused on planning processes, these factors do not satisfactorily explain my lack of discussion of the process and outcomes of the volunteer mentor consultation, for example. My efforts to write an acceptable paper were based on my internalisation of powerful professional and academic norms, such as the biomedical focus of the mental health system, which, for instance, privileged evaluation results based on application of the validated pre and post test GDS ratings, and the positivist scientific culture of research. I am uncomfortable now, in hindsight, that in reporting my work in this assignment I had acquiesced to prevailing professional and academic traditions and, in doing so, failed to stand with, and support the agency of the older women whose participation had contributed these outcomes of the program.

Yet, my desire to enter the academy was explicitly connected with my response to the invisibility of older people, among other experiences. Witnessing the experiences of older people with whom I worked in these programs fuelled a desire to ‘make a difference’. I intended to bring the diversity of experiences, perspectives, strengths and active meaning-making capacity of older people into the curriculum and make them visible, as individuals rather than patients, to students who are working, as I had done, within a health system that
privileges bio-medical knowledge within a neoliberal context and obscures older people as agents in their own lives. I hoped to share my practice knowledge and sought to inform and challenge students to be able to see each older person more clearly as him/herself so as to be able to work more effectively in partnership with them to promote their health and wellbeing. I felt I had both knowledge and experience to offer health workers on behalf of the older women and men I had worked with in Healthy & Wise, yet my assignment shows little evidence of this motivation or of personal and local knowledge which makes these older persons visible. In the ‘GER assignment’, and despite the subject focus on social understandings of ageing, my writing is aloof and abstracted from the people who gave the program meaning. These biases are echoed in much of the gerontology education literature.

Gerontology education literature is dominated by bio-medical, expert opinion and organisational and health system imperatives and I have found little that represents older people thoroughly and in their diversity. Interestingly I have since also found that neither my students nor the older people they work with are readily visible within the university education system that I now teach within. A contributing factor to the invisibility of older people is the comparative neglect of lived practice experience in the gerontology education literature.

In contrast, the tale ‘Wonderful, brave, together’ uses “writing as inquiry” (Richardson & Adams St. Pierre, 2005) to investigate my memories of actual
practice as a potential source of new learning and makes visible multiple forms of professional knowledge. Reflecting on my lived experience of working with Healthy & Wise, I see that the practice was suffused with my growing ‘professional craft knowledge’, consolidated by critical reflection on experiences, of group facilitation skills and the importance of the relationships created in the program. The practice of Healthy & Wise was highly contingent on the application of ‘personal knowledge’ in creating the opportunity for these relationships to develop, which is a vital feature of transformative learning.

The CFHCWOA (2008a) highlights the context of change within which gerontology practitioners will need to work, and claims, therefore, that their education must enable them to be flexible, able to problem-solve and adapt existing knowledge to new frameworks of care and policy contexts. I would argue that it is not just the capacity to adapt to changing policy, but the capacity to critique and develop policy and to create change at practice and institutional levels to enable better outcomes for older people, which is vital for gerontology practitioners as leaders. This demands a kind of ethical leadership focused on supporting conditions conducive to older people maximising their own agency.

Building on previous explorations of the nature of leadership in dementia care practice contexts (Aberdeen & Angus, 2005), Angus (2009) defines leadership as incorporating both a skilled practice focus on ethical, person-centred care and on management functions, within the context of the growing need for skilled dementia care, and within changing social, political, economic and
regulatory environments, where “staff in leadership roles need to have the ability to blend two professions grounded in health care and management practices” (p. S17). She outlines the complexity of the practice environment for gerontology graduates who are required to work both autonomously and within interdisciplinary teams and need the capacity to contribute to and drive organisational and social change, in addition to expertise in searching out information in support of complex problem-solving and decision-making skills. Angus (2009) advocates creating a systematic approach to embed leadership in the dementia and aged services curriculum and includes both principles of evidence-based health and ethics (as “the governance of care”) (p. S19) as key curriculum elements. These elements offer another example of the way different types of knowledge integrate in practice. Evidence based health practice relies heavily, although not entirely, on propositional knowledge and ethical practice involves an integration of the three forms of knowledge discussed. Practitioners learn about ethics in propositional knowledge from theory and from professional codes, they are then required to solve ethical problems in practice, using situated experience and professional craft knowledge, which they must enact by applying ethical values, such as reciprocity, in their personal interactions with clients and others. Beyond this study, there is little discussion of practice experience as a basis for knowledge generation in gerontology education literature.

Nonetheless, practitioner research and practice knowledge needs to be enacted, acknowledged and highlighted further if we are to work towards transformative
education. There is a strong focus within the wider health education literature on critical reflection using case studies from students’ own practice as a learning mechanism for practitioners (eg. Fook & Gardner, 2012; Schon, 1995) in order to engage students in questioning existing methods and what is currently taken for granted in practice. I use this method in my subjects. Angus (2009) argues that critical reflective practice is a tool that enables students “to promote values and to change attitudes - to challenge and make changes in institutions of caring that are often entrenched in hierarchical and mono-disciplinary traditions” (p. S20). This layered account further demonstrates the value of critical reflection on practice. The GER assignment offers tantalizing hints that there would have been more to learn about the practitioner process of planning for this program, including the linking of the development of the health education program within a broader community awareness strategy. It is a shame that I did not explore the ‘messy’ elements of this work, including the metaphors used (I used to talk about aiming that each step I took would have multiple effects, like ripples in a pool, and hoped to see these ripples create further ripples) and an explanation of how the eclectic influences on process linked together and influenced program structure and content. While my GER assignment provides an account of a reasonable and professional process of development and planning which underpinned this program at a broad level, ‘Wonderful, brave, together’ offers some insights into the ethical nature and requirements of the work, showing perhaps how broad health professional ethics (do no harm, do good, promote autonomy, justice) may be faced and enacted in a particular program and instance of health care. The tale shows the
level of care and responsiveness which went into the management of risk (eg. the seeking of participants input into the groups own ‘safety rules of engagement’, the follow-up between groups when indicated) and the achievement of safety in a program which faces life issues of a potentially distressing and emotional nature. While I did not consciously set out to write about the risk and safety issues, it seems that in wanting to show the depth and intensity of some of the interactions in the program and the courage and care of the women, I also needed to show that the program was well-planned and well-managed to support and keep safe those who were vulnerable. Though not directly noted in the tale, the initial registration process for the program, with full information and consent of participants, includes the use of the self-rating GDS scale, as both a screening tool to alert the worker of participants who may be struggling with depression and as an evaluatory tool making possible pre and post program comparisons, continuing its use in that way from the initial evaluations (Gattuso, 1999, 2000, 2003). The facilitator role is one of great complexity and requires significant skill and knowledge. This element of building into the program the ability to assess, monitor and appropriately support and/or refer on for appropriate services anyone who may be vulnerable and require such additional professional support, demonstrates more than any other, the integration of the three forms of professional practice. The tale shows how the relational elements of connection and support between participants that is generated in the program plays a highly significant role in the safety and support of those who may be vulnerable at any point. In addition to conveying
elements of an empowering program, ‘Wonderful, brave, together’ lays bare transgressive elements of my professional practice.

My writing reveals me, in my role of facilitator, as having doubts, uncertainty, fears and even being lost for words on occasion. This is no smooth story of a mythical program where “progress and success were certain and unequivocal” (Granger, 2011, p. 11), but rather includes the moments “when what is supposed to happen doesn’t happen:…. when the self, as learner or teacher, grows silent” (Granger, 2011, p. 7). While Granger is talking about formal education, she makes the point that these ‘silent moments’, when the everyday work is difficult or challenging, are a valuable source of learning, however usually pass unexamined. In this story, my potential fallibility is on show when the ground gets shaky following Stella’s robust challenge about the nature of depression. While I paused to consider how I would respond in words that would honour both Stella and the other women’s perspectives and act to validate the women’s expressions of their experiences in the face of this challenge, I was pre-empted at this critical point by Amelia’s intervention. What would I have said? How would I have managed to bring things to a positive conclusion? What can I learn from this? In moments like these, which occur quite frequently in group work, I used to feel such pressure, as “the expert” to save the day, rescue things, make it all smooth and safe, and avoid any conflict. This story shows, perhaps, my learning to trust in the women, in the group process, and to allow the connections and expectations carefully set up in the first few sessions (prior to tackling the more challenging issues) to
unfold. If I had intervened immediately I would have almost certainly been able to avoid distress and resolve the situation, but I would have, even more certainly, precluded the degree of learning and resolution as emerged from Amelia and Stella’s exchange. Did I pause, as an experienced group worker, to enable the group to lead? Or was it because I was at a loss, at that moment, to summon the ‘right’ words? A commentary that shows mistakes, fallibility or uncertainty enables me to shift myself from centre stage where my ‘performance’ as ‘expert’ may be the focus, and notice the group interactions which show the women in an alternative light as their own agents of change. This is important learning, as is recognition of the inevitability and value of mistakes, imperfections and ‘silent moments’ (Granger, 2011) in my performance of the complexities of professional practice and the opportunities for education and development offered by examination of these moments.

‘Wonderful, brave, together’ is also transgressive in that it reveals my feelings, emotions and standpoint as practitioner in a way that is not usually seen in academic or practitioner accounts. It is interesting to note, on re-reading, that I change pronouns within the tale, sometimes referring to “we” rather than “I”, for instance, as I describe the group responses to Stella’s comment. The use of the pronoun shows my standpoint clearly as one of the group, connected, on side, in solidarity with the other participants, sharing emotions. In professional training that emphasizes the objectivity of the expert and professional detachment as a requirement for appropriate practice this would be frowned upon. The tale shows that my emotional engagement with participants did not
entangle or reduce my capacity to carry out the facilitation role and it may be
that, reflecting on the elements of transformative learning articulated by
Hutchings (2010) and the pedagogy of care concepts of (Barnett, 2007), that
this authentic personal and emotional, as well as professional, engagement with
participants offers clues to the value they gained from the program and that
practitioners can position themselves differently and more equally within such
relationships.

**Conclusion**

The two texts examined in this layered account together create a much deeper,
richer and more generative representation of the Healthy & Wise program than
either could on their own, and this would be further deepened and enriched by
an account from the perspective of a participant(s). This interplay between the
lived experiences, robustly and critically reflected on, and the generalisable
knowledge of theory and quantitative evaluation enlivens a conversation about
what this program is really all about and what can be learnt from it, whereas a
focus solely on the propositional knowledge writes out the people, raises fewer
questions and impoverishes the learning potential.

Transformative education requires relational, collaborative, equitable, authentic
and mutual engagement with learning between teacher and learner. ‘Wonderful,
brave, together’ shows a process whereby participants were able to ‘speak their
world’ and be heard respectfully and that this was certainly experienced by
those who did so as empowering and may also, as noted above, be seen as transformative in its potential impact on the perspectives of some individuals (eg. Stella, Marion and others who spoke of their experiences). I can see now that my work with Healthy & Wise over my eight years of involvement also represented an experience of transformative learning for me and is still driving me to attempt to change the nature of health care for older people through my work in gerontology education.

The experience of working on this layered account has challenged me and given me new understandings about the work of Healthy & Wise and my autoethnographic examination of practice links with my ongoing commitment to gerontology education. To progress towards the gerontology practitioner as change agent (in addition to expert and professional), as Frenk, et al. (2010) advocate, may require us to seek, find and learn from the transformative elements that can be found in everyday practice work. This exercise has convinced me that this is possible. Yet, while the generation of practice knowledge via attention to professional craft and personal knowledge, and the use of critical reflective processes to engender ethical practice attuned to creating change, can be seen to be desirable outcomes of gerontology practice, it is instructive to consider how these elements can be achieved within health and academic cultures dominated by the power of, and situated within, overarching marketised neoliberal contexts.
CHAPTER FIVE: SPEAKING MY WORLD

Introduction

In this chapter I focus on ‘speaking my world’ by examining my experience of formal professional development within the academy on my pathway to becoming a teacher of gerontology and what it conveys about the realities of building and delivering transformative education. In the previous chapter I examined my learning from practice experiences of working with older people in ways that empowered them to ‘transform’ some aspects of their lives and revealed my motivation to move into teaching gerontology as a way that I hoped I might be able to begin to change the health systems that constrain and limit older people by offering transformative education to health professional students of gerontology who could go out and do this work as change agents.

How excited and naïve was my outlook on what I might be able to achieve as a gerontology educator within a tertiary education system that mirrors the health sector in its capacity to limit students and educators within the bounds of the prevailing neoliberal political environment and tightening budget constraints (Agbim & Ozanne, 2007)? The framework developed by the EHP Commission (Frenk, et al., 2010) examines the connections between education and health systems and “is centred on people as co-producers and as drivers of needs and
demands in both systems” (p. 1923). Frenk et al. (2010) conclude that “to have a positive effect on health outcomes, the professional education subsystem must design new instructional and institutional strategies” (p. 1923).

The EHP Commission’s call for health professionals to be offered transformative education to enable them to address the pressing issues of health inequities and social justice, as agents of change, is a challenge that gerontology education must take up urgently. Older people are more vulnerable to health inequities due to their exposure to ageist health systems and practices (Angus & Reeve, 2006; Cruikshank, 2006; Eymard & Douglas, 2012) in addition to the range of social determinants that constrain opportunities for health in the general population and are particularly at risk from the current alarmist discourse portraying the ageing population as a crisis that threatens the sustainability of health care (Coory, 2004; Cruikshank, 2006; Harper, 2006; Martin, et al., 2009; Poole, 2014). This discourse is used to justify policy decisions that further constrain access of older people to health and welfare supports, as has been apparent in the 2014 Australian Federal Budget provisions on the Aged Pension and on medical co-payments (Hockey, 2014). Transformative education for health professionals and for the gerontology educators, who are teaching them about issues of ageing and work with older people, is therefore crucial.

In this chapter I consider what can be learned from my experience of a particular professional development program, entitled Tertiary Teaching
Colloquium (TTC), about transformative education for health professionals (my students) and gerontology educators such as me. The TTC experience was chosen as a source of autoethnographic enquiry as I had an existing account (TTC report) that fits all my criteria for inclusion (ie. it is a formal text, submitted as a report to justify completion of the TTC program, it represents moments of change/transition and identity issues for me as a practitioner, and offers resonances between my own education as a teacher and my students in health practice) and allows critical reflection on the requirement of Frenk, et al. (2010) to co-produce transformative gerontology education.

The chapter begins with an introduction to my early academic career in gerontology and the TTC program, thus situating the texts for examination within the personal, professional and institutional contexts in which I was working and writing at that time. This is followed by a description of the ‘TTC report’ (which can be found in full in Appendix 4) and a critical re-reading of the Report that establishes the first text in this layered account sequence. The tale ‘Where do I stand?’ is introduced and then told, offering a new and alternative account of my experience of professional education within TTC. Finally, the two texts are analysed in relation to each other, focusing first on the institutional and cultural contexts of the program and their implications and secondly, on how participants, including myself, exercised their agency to mitigate the counter-productive structural features of the program as an artefact of an ‘enterprise university’. Threaded through the analysis is my overarching
search for knowledge about what might constitute transformative education for gerontology practice and how it might be realised.

**TTC in cultural context**

In this section, I provide an outline of the personal, professional and institutional contexts of my work at CSU during my early academic career and leading up to my experience of attending TTC as my major professional development opportunity in becoming a gerontology educator in which the writing of my ‘TTC report’ took place. I commenced employment in the gerontology program at CSU in 1998 as a sessional marker, with prior experience of sessional teaching in the Social Work degree at La Trobe University. The Bachelor of Health Sciences (Gerontology), the first gerontology course delivered via distance education in Australia, had been introduced in 1994, and the Master and Graduate Certificate in Gerontology had been established in 1998 and 2001 respectively. The courses are based on a critical social gerontology model, teaching bio-psycho-social perspectives (informative education) and with a strong emphasis on linking theory with ethical professional practice (formative education). From mid 2005 I worked sessionally and on a part-time contract, marking and teaching in a number of subjects. Also during this time the decision had been made to phase out the Bachelor degree and gerontology staffing had been reduced from previous levels. Literature indicates that such under-investment in gerontology education and educators is not dissimilar to other gerontology courses in Australia and
internationally (Askham, et al., 2007; CFHCWOA, 2008; Russell, et al., 2007; Sterns & Ferraro, 2008). Nadash et al. (2013) describe a highly resourced and seemingly high-quality program, with similar technological features to the course in which I teach but, apparently, marked differences in the level of resources directed to achieving a similar expected outcome. I applied for the permanent position of lecturer when it became available. There does not seem to be strong supply of gerontology academics ready to teach in universities (Askham, et al., 2007; Russell, et al., 2007) and, so it is not surprising that a regional university, such as CSU, may fail to attract a wide range of qualified and experienced applicants in such a non-traditional discipline as gerontology. My appointment to the position was made on the basis of professional equivalency together with my demonstrated achievements as a sessional/contracted staff member. A faculty restructure during 2006 meant that when I commenced full-time in the new role in January 2007, the gerontology courses had moved from the SoCH in the Faculty of Health Science to the School of Humanities and Social Sciences (H&SS) in the Faculty of Arts. CSU is a multi-campus regional university in New South Wales. With only a small number of H&SS colleagues on campus and the Head of School on another campus, the position represented a degree of isolation from formal supports. Amongst key structural features to which Nadash, et al. (2013) credit success of their program are its location within a well-established academic gerontology department which also produces PhD graduates in gerontology, a management structure which includes gerontology academics at senior leadership positions both within the program and within the auspice university, and a high level of
resources – both in staffing and funding for the program (Nadash, et al., 2013, p. 4). These advantages were not shared by the course in which I began to teach.

I had been in the fulltime role for only a matter of months when a visitor from Faculty disrupted the warm morning tea welcome extended to him with the bombshell that the Gerontology courses, low in student numbers after an unsettled staffing period, was listed for possible closure. To even consider closing a gerontology course in a period of population ageing seemed crazy! This threat of closure weighed heavily on me and I was very strongly motivated to work towards developing the course and contributing to its success not only in order to secure a career but also, in accordance with my original motivation, to be able to better equip people working in health and ageing to change and improve policy, health promotional and treatment outcomes with older people. The role took on the form of a mission or quest, which gave great shape to my life and work at the time. Something I needed and wanted to do well.

At the same time I was conscious of beginning a new career in academia at a time which would be considered ‘late’ by usual standards. Having also entered parenthood somewhat late in life, I still had two children at school, requiring considerable practical and emotional parenting. Work-life balance was elusive and challenging. Chronologically, my transition into teaching gerontology mirrored my transition into becoming an older person myself, although neither in my work nor private life did I feel ‘older’! While I frequently felt stressed by
the work and slept poorly, I usually also felt enthusiasm and optimism and sometimes even exhilaration. I loved the developmental work with students and with the course curricula. The CSU gerontology program now has a strong enrolment of over 100 health practitioners within the course and positive student evaluations and graduate outcomes.

My expectation on commencing as a lecturer was that substantial and specific initial teacher training would be available, contextualised to embrace teaching in distance and face to face modes, and across discipline areas and levels. I don’t recall that this expectation was necessarily based on recruitment information. It may have been an untested assumption that I brought with me and an unrealistic view of academia. While there are, indeed, opportunities within the academy for learning about teaching, they were then neither readily apparent nor especially accessible to a new academic, particularly one entering without an apprenticeship via the traditional higher research degree/tutoring background, and with a high immediate teaching workload. The reality I found was that initial teaching skills appeared to be largely learned on the job. In contrast, CSU has since developed two teaching education subjects that are mandatory for all new academics, linked to a Graduate Certificate in Teaching and Learning in Higher Education. In 2008 the TTC was the mandatory CSU orientation and teacher education process for both new academics and experienced academics new to CSU. It consisted of two single day sessions at Wagga campus and one two-day residential program at the Bathurst campus, plus an assessable follow-up project.
An organisational account: TTC report

The first text in this layered account is an organisational account of my experience with the TTC program, which I refer to as the ‘TTC report’ (Appendix 4). The report was written solely as a requirement of the TTC process and as a means to ‘tick the box’ of successfully completing the TTC learning experience. The required topic for the report had been set up as an account of an individual teaching project carried out on the basis of initial exploration and small group discussions at the final TTC day workshop. As I had been unable to attend this session I had submitted my potential topic as an alternative and been pleased to be approved to provide a reflective report on the process and outcomes of revision of the subject GER401 in order to develop a skills module embedded in the subject content. Given the arrangements, I had no opportunity to discuss this project with other academics from the TTC group and the report therefore is written from my sole perspective, which may contribute to its limitations. In the process of redeveloping the subject curriculum, however, I worked collaboratively with one of the TTC presenters on this topic and with colleagues from the Learning Skills and Library staff.

Re-reading the ‘TTC report’ of 2008, in 2014, I find an uncritical description of a series of actions and events, beginning with a presentation experienced as part of the TTC and leading up to curriculum changes within the subject GER401 Choices and Options in Later Life. Although the agreed task was to “write a
reflective piece about my learning from the process”, there is more description than reflection and no evidence of pedagogical enquiry or claims on teaching theory to support my project. The tone of the report is enthusiastic and somewhat self-congratulatory. It is not hard for the reader to perceive my pleasure at the process and outcome described and a sense of pride I felt in the achievement of this revision of GER401 to specifically build students’ academic skills within the content of the subject. This ‘celebratory account’ (Groundwater-Smith & Mockler, 2007) in no way fully represents the challenges, barriers, difficulties and doubts which I experienced along the way, nor the learning I gained from the process that should have been a key feature of this assessment piece. There is a limited attempt to situate the text within the context of the lived experience of my students (which inspired, in the first instance, these actions) and little of my own lived experience of academic teaching or learning in the TTC context. My reflections on the process do not disturb the surface of the pool of potential narratives about the actual TTC experience and/or the experience of developing the embedded academic skills subject content which is the focus of the report. My identification of learning from the process is under-developed and superficial. My learning from the TTC process and this project is cited as a reminder of the value of collegial collaboration and an endorsement of the value of embedding critical skills within subject content of relevance to the students. However, collegial collaboration is something which I have long considered a strength, throughout my social work and teaching career, and I readily adopted the idea of embedding basic academic literacy skills within gerontology subject content.
because it matched my existing (limited) teaching perspective of ‘starting from where the student is at’ and my understandings of the needs of my particular student cohort. There is little evidence of significant learning about teaching in this account. I had cleared the hurdle, but what had I learned and where did I stand as a gerontology educator?

**The untold story: ‘Where do I stand?’**

My turn to attend TTC brought with it a mix of anticipation and apprehension. I was hungry to learn about teaching practitioners in the tertiary distance education context and keen to learn and develop my skills. On the other hand, I was concerned about whether the experience was going to meet my expectations and needs. I was also a little apprehensive about whether I would be out of my depth within the academic cohort, due to my lack of experience in teaching and my lack of formal academic qualifications. I felt some concern that my teaching inadequacies might be exposed within the program. I couldn’t even use the term ‘pedagogy’ without feeling pompous and inadequate, so how was I going to cope with the potential range of other educational jargon that I might neither recognise nor identify with? The constant feeling of stress in attempting to meet my busy teaching and course coordination workload had prompted me to gain an exemption from undertaking TTC in 2007. The workload issue still weighed heavily on my mind as the program approached and obscured any anticipation of the potential benefits from the program.
The limited resources of TTC constituted the first and only formal source of teacher training accessible to me as a new academic appointed on the basis of professional equivalency rather than academic ‘apprenticeship’. TTC, therefore, was required to bear the weight of my initial professional development for teaching hopes and expectations, so it is not surprising that I felt so inadequate to respond authentically to the first task I encountered in the TTC program, wherein the forty or so participants were requested to stand up and place ourselves in a line across the room, on a continuum between teacher focussed or student focussed teachers.

_TTC Session 1 March/April 2008, Wagga Wagga Campus._

“Where do I stand, as an academic, on a continuum between teacher-focussed and student-focussed teaching?” I repeat the question in my mind, blankly.

From being comfortably seated, and gently expectant, waiting within this spacious conference room, with the wall of glass and sweeping views over gently rolling hills outside Wagga, for the morning session to begin, we were to immediately stand up and form a line across the room, bodily representing where we would place ourselves along this continuum. Oh, how self-revealing! Stand up and be counted! But where do I stand? Panic begins to rise in my throat.
“Oh my goodness, how would I know? S***! It’s not something I’ve thought much about and now I’m going to be caught out, revealing my teaching inadequacies…. (wiping suddenly sweaty palms on my jeans). Oh dear! Where are other people I know placing themselves? Beam me up, Scotty! Help!”

I stand up, hoping to look outwardly calm, appearing to wait courteously for others to take their chosen positions, while my mind hammers away in circles. Where to place myself? Is there safety in the middle-ground? My own brand of ‘imposter syndrome’, always quietly hovering in the shadows, is feeding on the situation, larger than life, in centre-stage, “See, you’re no academic! What are you doing here anyway, you fraud”, the voice is clamouring as I hover for a few more seconds before sliding alongside a huddle of people a little to the student side of the centre of the line of people. I glance around me at my new neighbours, fellow teachers claiming the centre ground. Centre-centredness? Are they positioned centrally because this is their considered opinion of where they would place their teaching philosophy or are they, like me, trying for inoffensive, on the fence, ‘just don’t get it wrong’? My pedagogical stance is no stance at all. I can’t even say the ‘P’ word without feeling pretentious and ignorant. Oh no, welcome to TTC!..........................

Robin looked around, checking out the faces and trying to track the sense of discomfort and tension in the room. It seemed that she was not the only one to feel uncomfortable during this activity. Perhaps not for the same reasons though? Once re-seated, discussion of the exercise developed somewhat
stormily around her. She was more conscious of the mood than the content of
 debate - there was a sense of clashing, jaggedness, clanging, disjunctions....
The exercise had raised the ire of some participants, who showed this in a
variety of the ways open to articulate and strongly opined academics, from
pointed diatribes to vivid rhetoric to obvious disengagement. There was
concern expressed that the task and discussion which surrounded it might be
over-simplifying a complex issue. The issue of where the focus of teaching is
located – on the student’s needs or on those of the teacher (or perhaps devolved
to organisational/professional requirements for specific knowledge or
particular teaching models or technologies?), seemed an important one which
could have generated much useful discussion. Has this exercise profoundly
illuminated the question wondered Robin, her mind drifting back, and away
from the next topic). Perhaps it may have, as an example of a top-down
‘teacher-centred’ activity, although not in the way it may have been planned.
Presenting valid ideas in a way which fails to engage learners is doomed to be
ineffective. But were the learners open to be engaged or were there prior
organisational issues about the program which set a mood of disquiet from the
start? If so, this surely represents all the more need to start from where the
learners are? “Perhaps I should have been further along the line towards
student centred?” thought Robin, calmer now and able to reflect on her
teaching experiences. She shifted uncomfortably in her seat, trying to ease the
embodied tension in the room and wondering how to apply this to her students.
‘What does this mean for Julie?’ she asks herself, grounding her thoughts in a
real-life remembered scenario...
4.45pm July 2007, Robin’s office, Irvington, CSU Albury Campus

Robin is working on writing a new subject, and beginning to feel stiff from sitting at the computer for a long stretch, when the phone rings. She answers it and sits back in her clumsy old armed desk-chair, stretching out her legs under the desk. It is a cold afternoon and the light coming through the crack in the wall of her office is dull and fading as she talks to Julie, a student who has begun the Graduate Certificate in Gerontology this session. Julie explains that she has arranged to take an hour off her work as an Enrolled Nurse in a residential care facility in order to be able to call Robin during business hours and has a list of questions to ask about the assignment as well as seeking an extension. She talks about her work in residential care with enthusiasm and commitment while acknowledging her tiredness and frustration with low staffing levels and the need to take on extra shifts to help out. She is married, in her 40’s, with two children, and has worked in aged care for 15 years. Julie tells Robin about her current difficulties in balancing care for her father, who has been recently diagnosed with cancer, as well as her work, children and study. Julie is keen to study gerontology because she sees it as a way to contribute to improved care for the residents in her facility and to potentially give herself a career path in aged care. She is keen to learn, but feeling confused and overwhelmed by the study. She is struggling, not just with time to study, but also with the academic requirements. Her previous study has been at a TAFE Diploma level, very practice based and several years ago. She is
unfamiliar with working and researching information online and lacks confidence in negotiating the CSU student and library sites, has no experience of writing essays and confesses that she has been feeling demoralised and a failure. It is a long phone call, discussing options for library help and study support as well as discussing the essay topic and ways to prepare and write. Robin tries to be both encouraging and realistic about the study requirements. Julie’s story is heartfelt and moving. It brings the issue of preparedness for study into fine focus for Robin.

Back in her office on the day after the first session of TTC, Robin made some notes about ideas arising from it that she hoped might be of value to her teaching of students like Julie. A series of dot points included this one: “Develop library and online lit./data base search skills hurdle for new students to course (GER402/401)”. The notes indicated that the session held some interest and relevance to her; however, despite the focus of discussions in the day-long session, she had generated no dot points on pedagogical theory or student/teacher centredness.

Looking back on her memories of this session later, she can’t recall the details of the discussion or the outcomes. What she can remember, viscerally, is her fear of being exposed as a fraud amongst ‘real’ academics, her lack of ‘fit’ as a gerontology teacher of diverse adult practitioners amongst academics who seemed to be mainly teaching undergraduate students in preparation for
practice, and, beneath the words being bandied about, a rumbling undercurrent of dissatisfaction in the room.

Despite the few valuable remnant ideas from day one of TTC, Robin is not looking forward to the next session – a two day residential component to be held at Bathurst in June, during the brief fortnight between teaching semesters. The timing signals that formal development of her teaching as a tertiary educator, along with the profound openness and willingness to expose herself to new ideas and clarity of focus which she suspects might be required for such development, is to be shoehorned into marking time, when grade entry deadlines channel all efforts and drive all schedules. Robin feels, already, a dull sense of dread and resentment at the impost this will make on her efforts to mark efficiently and provide thorough and effective feedback to students in the short time-frame allowed for assignment turn-around. She shrugs off the dread and forgets about both the feelings and TTC itself, buried in work until the day comes.

TTC Session 2 June, 2008, Bathurst Campus

Here she is in Bathurst in June. The residential TTC sessions are beginning. The air is bracing on the cold wintry campus but there is warmth and collegiality in meeting up with academics from other campuses. There is a greater opportunity to mingle on this occasion and this is a pleasure. Robin is surprised to find how many here are already experienced academics, newly
moved to CSU, with a variety of interesting and diverse experiences from other universities and situations. Diverse ages, academic disciplines, levels of advancement, areas of intellectual pursuit and passion. Despite her general lack of enthusiasm for TTC she feels a tingle of anticipation at the possibility of rich discussions, which she knows she will not initiate, but which she hopes she will be able to witness and share. Along with the friendliness, Robin has dragged an amorphous, sinking feeling of inadequacy with her, the good old imposter syndrome again, heightened by her experiences of the first TTC session. A gnawing sense of stress reminds her of the pile of unmarked essays squatting on the laminated desk in her motel style campus accommodation. The pink pile looms over her evening ahead.

A new facilitator introduces herself for this session. She has, herself, newly returned to CSU in an educational designer role. Very newly returned. It is her first week back. She is running a program already planned and set up for her by someone else. This will be a tough gig. She appears friendly, open, skilled and up to the role. The room is large, warm and set up like a traditional classroom with rows of chairs all facing the front, where the computer and the blank white screen defy interactive modes of learning.

The program schedule lists a series of presentations on different aspects of teaching or teaching programs at CSU. All worthy, none seem targeted to participant learning needs. It is wall to wall power-point presentations, showcasing the work of various university sanctioned projects and research groups
on teaching, with some time for desultory questions interspersed within or at the end. The scones, jam and cream for morning tea have never been so welcome. The day wears wearily on.

Robin had struggled to find much of relevance to her particular needs during the day’s program. Much of the discussion was about teaching undergraduates, how to engage reluctant straight-from-school learners, taking up the latest in online teaching tools for tech savvy students, preparing students for practice. She feels that she and her students are not the learners assumed by the TTC program or discussed by other participants. As she lugs a stack of essays to the queen bed and props herself up with pillows against the bed-head, lap-top on her knees, she hopes for better in the next day’s program. One session, in particular, sounds interesting, it will perhaps offer a way forward for her to address her issue of building academic skills early in the course to enable all new students to have the skills to make the best use possible of their study?

Robin picks up the first assignment from the pile (the pale pink of the university face-pages is a colour which is rapidly losing its appeal) and rubs her eyes before beginning to read and formulate feedback.

Once again, the next day, a low grumble of discontent builds amongst the group, perhaps feeding on the tiredness of midnight marking and the stress of grade entry deadlines? As the presentations proceed, many of those with existing university teaching experience are finding the content not relevant to their needs and the rumbling is becoming a low roar of open dissension and
resentment. Instead of novice academics getting the benefit of rich discussions with more experienced colleagues about issues of mutual interest and experienced academics gaining fresh perspectives and questions from newbies, the program grinds on in lecture style with, at best, a significant proportion of participants disengaged. During one session a discussion veers headlong into friction between proponents of quantitative and qualitative research methodologies. Potentially a subject for fruitful and wide-ranging debate about the relative merits and different benefits of each methodology, proponents instead seem to be adhering to rigid orthodox railway lines of argument with no intersecting points visible in the middle distance. Tempers rise and spill over somewhat, before eventually, running out of steam, the about-to-be runaway train of argument is instead shunted into a hot and tetchy dead end. Stale-mate. No one seems satisfied. Robin hates the tension, rolls her shoulders to relieve it and wishes she was anywhere else but here. There has been no evidence of a lack of collegiality in the informal interactions between participants yet the tension in the classroom is palpable and threatens to split the group.

Lunch is plentiful and a relief, a highpoint in the day so far. Mingling, over plates of bulging sandwiches and tasty mini-quiches and fruit, the tension has dissipated and the noise of spirited conversations and laughter is relaxed and boisterous.

Back in the classroom, however, the tension quickly returns and, finally, inevitably, spills over at the beginning of a new session. It is the session that
Robin has been eagerly awaiting. The presenters have only just begun their session entitled “Embedding Academic and Information Literacy into your Teaching” when a question from the room signals open mutiny. The merits of the whole TTC program are under question and the heat is on. Is this the best that can be done in a formal education session by educators for academics to develop teaching skills and knowledge? There are many people in the room wanting to articulate their frustrations about an educational process which they feel has been imposed on them rather than designed for them. Where is the student-centredness in this educational experience?

Robin sits outwardly silent within the melee, however she can feel her agitation growing. Where does she stand? She is on both sides of this argument simultaneously. She feels frustration about the program, for herself and for other participants, some of whom are now representing themselves with passion and force, but she also harbours a strong desire to have everyone please JUST SHUT UP so that she can find out about what these presenters have to offer her. She is squirming, also, on behalf of the presenters, whose unlucky timing has left them stranded at the front of the room, open-mouthed and, maybe, wondering where they have gone wrong, although this is not really about them. She feels for the facilitator, whose own unfortunate timing has placed her here in front of this rowdy and rebellious group of academics, taking responsibility for a program she has played no role in creating.
The heat and light flares for some time, or so it feels to Robin, twisting around in her hard, moulded-plastic chair, to face each speaker in turn, head turning as if at a tennis match, trying to keep up with the frenetic energy of the exchanges. She is not comfortable with conflict and is a bit shocked to find her own anger growing (‘please everyone just shut up so we can continue! I really want to hear these people, they have something I need to know about’) and then feels guilty at negating the needs of others. Is she putting her own immediate interests ahead of longer term goals of reforming TTC and the pedagogical needs of others in the group? (‘Who cares, can I please just hear this session! Is that too much to ask?! Ok, it’s an instrumental goal but it’s important to me right now!). Her inner tension grows and threatens to explode, but is contained by a stronger sense of being at odds with the group, an imposter, not a real academic and therefore of dubious validity in this turbulent room. She grows even less sure where she stands, where she should stand. She doesn’t speak up. She feels stuck, her mind flapping ineffectually, unable to move either way. Trapped in a classroom where a clash between competing ideas of student-centred and teacher-centred learning is being played out in practice, loudly, to her discomfort.

The facilitator doesn’t need Robin’s concern for her, however, she is made of stronger stuff. She listens actively, draws out key issues to reflect back for validation and then, finally, is able to redirect the energy, somewhat, into a search for a solution, negotiating to reorganize the program for the final upcoming session in Wagga with the aim of better meeting participants
expressed needs. With a sense of being heard and a tentative plan for improvement in place, the room settles and the presentation resumes. Robin relaxes and takes copious notes, these ideas, which have been created for and implemented with a cohort of professional paramedics as students, will indeed help her shape her teaching to ‘embed’ academic skills in an early subject of the course. She begins to feel excited by the prospect of being able to achieve a significant improvement in the course for Julie and the other students like her.

TTC project, July/August/September 2008, Albury Campus

There is energy and excitement in her discussions with Bronwyn (pseudonyms used) in the weeks following Bathurst and in her meetings with Val, from Learning Skills and John, from the Library, who she recruits to contribute their expertise to the new skills modules. She finds a fortuitous synergy in the existing topic on Lifelong Learning in GER401 which will make a great home for a new online module on building academic skills and knowledge for these students own lifelong learning, juxtaposing with and grounding material on lifelong learning for older people. Brownyn, Val and John enjoy the challenge and the collaboration in setting up these modules, learning from each other and aiming to accommodate the perceived needs of this group of students. Val’s and John’s work is vital and appreciated. GER401 is transformed for its next offering. Robin feels excitement and apprehension, ‘how will the students find it? Have we got it right? Will it meet their needs?’ (Despite some minor technical difficulties, the students’ feedback from the first offering of the revised
subject is positive. Student evaluations indicate that most of them found the 
skills modules useful and the improved quality of their assignments reflects this. 
Those students who already have these skills seemed comfortable, rather than 
frustrated, by the requirement to refresh their knowledge. Robin is pleased and 
there is a reduction in students failing the subject).

The final session of TTC occurs some weeks later in Wagga. Participants have 
been asked to prepare a project, of value to their teaching, on which they will 
work with others during the session. Robin is, all things considered, grateful to 
have a clash with a medical specialist’s appointment for which she has been 
waiting some time. This makes a good reason to be excused from the final 
session. She may be wasting a great opportunity to work with others, to learn 
about pedagogies relevant to her teaching, to develop and refine her teaching 
focus? However, wary from her experiences of the past sessions, she is no 
longer confident of any of this. Instead she negotiates the criteria for a final 
report, focussing on her project of embedding academic skills in the subject 
GER401 Choices and Options in Later Life, which has developed from that key 
presentation at Bathurst.

A report is written as the requirement for evaluation of her TTC participation. 
It is a somewhat celebratory, superficial account of the development of the 
skills modules. Robin is notified that her report has been assessed as 
satisfactory and she has ‘passed’ TTC. There is no significant feedback 
provided.
Critical reflection

In this section I develop a critical commentary on the two texts, ‘Where do I stand?’ and my ‘TTC report’, examining the connections, gaps and differences between these two representations of my TTC experience. A critical re-reading of both texts leads to the identification of a number of issues, which may otherwise have passed unnoticed. It also supports a rich examination of these issues and values transgressive as against institutional accounts. Read together, these tales tell, in different ways, something about a range of issues which, although they may be particular in my way of experiencing them, may also link to the experiences of other early academics, via the cultural and social norms thus revealed for examination.

In this analysis I ‘speak my world’ as an academic, working within the specific institutional and cultural context and attempting to achieve excellent outcomes for my students and their older clients. Issues arising at the personal level include the ‘fragility’ of academic identity and imposter syndrome (Knights & Clarke, 2014) and my efforts, as a teaching academic, to negotiate institutional/
student/client tensions. The title of the tale ‘Where do I stand?’ represents, not just where I stand on the student/teacher centred continuum, but also the central dilemma for me (and perhaps for other teaching academics) as to whether I act to support the status quo within the university (and thus reinforce institutional and social controls that limit education to largely informative and formative processes) or act as an agent of change myself, in an attempt to develop transformative education that will fit my students to change the complex health systems and workplaces they inhabit in order to enable social justice and provide equitable, high quality health services for older people.

The power of institutional and professional cultures

On re-reading the ‘TTC report’, written for the purpose of ‘passing’ the TTC program, it is clear that my aim was not only to represent my identity as that of a competent practitioner/academic but also to represent a developing competence based on learning from the program. For example, in the following quotes from the ‘TTC report’ I am attributing the influence of a particular TTC presentation on my curriculum development project:

I was inspired by the Bathurst residential session on embedding information and academic literacy skills into subjects… the potential for building not only library but also academic skills into a subject was revealed to me in the presentation ...entitled “Embedding Academic and Information Literacy into your Teaching.” I found the ideas in this presentation really exciting
as they appeared to offer a process and potential solutions to a similar issue to mine.

This attribution of curriculum development to the TTC experience is, at once, both quite fair and accurate, but is also limited by what is not discussed in relation to learning from the program. This account represents the project of embedding academic skills in a foundational subject of the gerontology course as a smooth, sequential and successful teaching development, and it is, indeed, some of these things. Yet, like my ‘GER assignment’, the ‘TTC report’ is a celebratory account. The project is described in instrumental and uncritical terms and the learning identified is limited to an uncontentious and superficial statement about the power and potential of collaborative engagements with interdisciplinary colleagues and a new understanding of integrating skills into content in curriculum. There is a lack of educational theory to either support or critique the project and little reflection on the process, despite reflection being a requirement of the task. In leaving out the uncomfortable and jarring aspects of the TTC experience and focusing on the identification and implementation of a specific task, this report leaves much untold that could have been a source of deeper learning. For example, it is only when reading the ‘TTC report’ against ‘Where do I stand?’ that my academic identity is highlighted, problematized and represented as changing and fluid, both in response to, and in actively co-constructing, the situations and their meanings that I experienced within TTC.

While the ‘TTC report’ represents the smooth adoption and implementation of an educational idea, sourced from TTC, as a quick and easy technical ‘fix’ for
educational challenges facing a particular group of my students, ‘Where do I stand?’ reveals many uncertainties, disjunctures and frustrations that dominated my experience of TTC and hints at broader uncertainties and disjunctures underlying the structure and content of the program. The tale highlights disconnections and problems evident in the content and implementation of the program, in part due to a succession of facilitators who lacked ‘ownership’ of the program and/or a voice in its design. The assumption by planners that facilitators could be interchangeable ultimately precluded a coherent educative progression of content and process. The timing (during an intensive marking period), target cohort (mixing new academics with experienced ones new to the institution) and the lack of contextualisation of teaching and content to reflect the participants’ particular learning needs, challenges, student cohorts and expertise, also speaks to this professional education experience being designed largely to meet organisational needs, rather than pedagogical challenges and opportunities. Hence, the TTC program and my report on it represent another example of provider-centrism, driven by larger structural forces discussed below, that once again rendered participants, including myself, largely invisible.

The celebratory account was only made possible by marginalising (direct and indirect) participants’ experiences. For example, the students are both my ‘clients’ to whom I have a responsibility for support and advocacy, and my partners in education, with whom I hope to be able to contribute to better health services for older people. Yet, while the learning needs of some of my students
for foundational academic study skills were the reason to undertake this curriculum development project, I made only a cursory attempt in the ‘TTC report’ to represent the students as individuals or as a cohort with very different characteristics and learning needs to the young, straight-from-school, undergraduates who seemed to be the more typical students referred to in presentations and discussions at TTC. The invisibility of students (both academics as learners/participants in TTC and our own students as the whole reason for being of TTC and the eventual ‘recipients’ of our teaching), and the incapacity of TTC to match pedagogies and curricula to my diverse health professional students and their workplace need for transformative education to produce leaders in health, are patent (Frenk, et al., 2010).

Other academic participants are not present at all in my ‘TTC report’ and, although playing a significant role in ‘Where do I stand?’ through their disruption of the program during the ‘mutiny’ at Bathurst, are only sketchily represented in this text, mainly as an undifferentiated group. It is important to recognise that my fellow participants in TTC are only a shadowy group in my writings and, in fact, could not be other than this because I have little memory of individual participants from the course. In my experiences of many educational events, such as workshops and conferences, the connections made with other participants are often as valuable an outcome as the knowledge gained through the content of the program. Reflecting now on the limited presence of other participants in either of my texts, I realise that I had made no new lasting connections as a result of this experience. The only other academics
I can recall attending the program with me were several people I knew independently of the program and still work with collegially. I remember enjoying discussions with an academic working in theatre and performing arts at Wagga but have no recollection of name or face now. I did mix and enjoy conversations with others in the break times, but clearly did not form any friendships or significant collegial relationships. This may have been different if I had attended the final, group-based session of the program where a much greater level of interaction would have occurred. While my lack of new connections may partly represent my personal response to the TTC social and cultural environment (was I perhaps guarded because of my sense of inadequacy as a teacher within this group?), it may also reflect features of the structure and culture of the program, already described, that acted to negate the relational aspects that Barnett (2007), Hutchings (2010) and Angus (2009) consider central to the teaching and learning process. I now see this lack of new connections as a wasted opportunity. This also limits my understanding of the individual perspectives of those who stood up to disrupt the program and restricts my ability to examine this incident other than through my point of view along with my perceptions of the general ‘feeling’ within the group at the time.

The many presenters, who may also under different circumstances have become valuable colleagues, are also rendered invisible in my texts, despite the time, energy and passion with which they may have approached their prescribed roles in this program. For the most part, their work at the time did not engage my interest, presumably as I did not perceive their offerings as
being highly relevant to my students needs and/or my teaching challenges. On the other hand, meaningful interaction with academics who did speak to my priorities was precluded. The group of academics responsible for the Embedding Academic and Information Literacy into your Teaching session had created this innovation in response to the needs and characteristics of their own student group of practising paramedics, many of whom shared characteristics with my students. I was able to translate this process easily and to good effect into a subject in my course because there was a good match between the purpose of the project and the student cohort for whom it had been originally designed and my own student cohort. How much more beneficial could have been the sharing between myself and these academics if I had been able to choose to pursue this area of learning, rather than sample the whole range of educational products on offer during TTC? While the longer term outcome from TTC for me as an academic and for my students through my project was a profound improvement in this subject, evidenced over time by student responses to the revised subject materials and assessment quality, the formal structure and content of TTC could have been much better focused to maximise my learning and my ability to translate this into transformational education for my students. This observation supports the importance of a student-centred focus for teaching that, despite being introduced in a contentious manner at the first session, was in no way enacted throughout the TTC program.

Not dissimilar to the Healthy & Wise participant who noted her frequent sense of invisibility, I was made to feel invisible within the TTC program from the
very first session. In Wagga, on that opening morning of TTC, the invisibility of my needs as a new academic contributed to my sense of fraudulence, which was exacerbated by my consciousness of actual differences, as well as my perceptions of the meaning of these differences. As an academic appointed on the basis of professional equivalence rather than academic achievement I felt that I was less worthy than those with the ‘correct’ academic qualifications – an imposter. This ‘devaluing’ is entrenched in the culture of universities which espouse narrow definitions of academic success, (usually based on research and publishing achievements and other income-generating entrepreneurial outcomes (Agbim & Ozanne, 2007) rather than on professional practice or, even teaching expertise). Academic career structures do not equally recognize professional practice in promotion processes, for instance. In combination with a general paucity of professional development opportunities for academic teachers, those with specific requirements who are transitioning from professional practice, for example, are especially disadvantaged (Green & Gates, 2013).

‘Imposter syndrome’ is a term first coined by Clance & Imes in 1978 (Knights & Clarke, 2014, p. 341) and is defined as a belief, despite evidence to the contrary, that one is less capable and competent than others believe one to be, or than one’s work requires, thus leading to a perception of one’s fraudulence. Knights & Clarke (2014) include this as one of three emergent types of insecurity associated with what they describe as ‘fragile academic selves’ and note its general attribution, in part, to personality characteristics of perfectionism and self-doubt, but themselves regard it, rather, as “a common
response to the presence of idealized images and expectations” (p. 341). These images and expectations are often institutionally promoted but may be unattainable due to other pressures or limitations of the workplace, however, individual academics internalise this inability to achieve the unattainable as being due to their own inadequacy, rather than as a systemic issue. It is reportedly more common in women and those from minority groups, especially those who have benefited from affirmative action, and is associated with a tendency to attribute success to external factors (eg. support, luck) and failure to internal factors (eg. personal inadequacy, laziness) (Knights & Clarke, 2014). According to these authors it is a common phenomenon amongst academics, and is associated with features of university social organization such as high levels of managerialism, performance requirements, auditing and evaluation and intensive workloads (Knights & Clarke, 2014). Under imposter syndrome academic staff may blame themselves for being unable to meet organisational requirements rather than interrogate the organisational and political culture implicated in the barriers preventing the achievement of idealised expectations. Hence, “… idealized expectations can engender a sense of failure or of being an imposter whereby we are sceptical of the limited social confirmations of self that come our way” (Knights & Clarke, 2014, p. 352; original emphasis). The first time I recall feeling like an imposter was early in my social work career and this has been a persistent, although episodic, experience throughout my working life so it would seem that aspects of my personality, perhaps in keeping with my gender socialization (Knights & Clarke, 2014) may predispose me towards self-doubt. However, it may also indicate my experience of the
prevalence of institutionally promoted, idealised expectations alongside systemic barriers to achievement (such as excessive workload) within a wide range of workplaces in the health as well as the higher education sectors (Knights & Clarke, 2014). The mismatch of my expectations of academia with the reality which I found and the disjuncture with the institutional expectations of teaching academics was significant. Unrealistic expectations of academics by the institutions are also promoted by the prevalence of ‘celebratory accounts’ (Denshire, 2014; Groundwater-Smith & Mockler, 2007) in official documentation, which leave out the problems and barriers encountered in any endeavour, in favour of a simplistic, untroubled and positive version of events. As academics attempt to measure their necessarily imperfect experiences against such celebratory accounts it is not surprising that many may judge themselves harshly for not matching up.

The analysis in Chapter Four of my ‘GER assignment’ identified it as a ‘celebratory account’ of practice (Groundwater-Smith & Mockler, 2007), which conformed to my internalised concepts of what is institutionally valued in reporting practice, in academic writing, and in which the peer mentors and program participants were written out of the story of the Healthy & Wise program. Similarly, the ‘TTC report’ presented a narrow and thin view of my TTC learning which excluded other participants and most of the presenters, most of the teaching content and the contentious and turbulent social process of the program, and concentrated solely on the simple representation of my smooth and unproblematic accomplishment of an instrumental curriculum
development task. In so doing, I offered a version of my learning that conformed to what Granger (2011, p. 11) claims as a predominant view within Western teaching and learning, that the simple application of a currently favoured ‘technical fix’ or curriculum strategy will almost automatically afford successful educational outcomes.

After re-reading the ‘TTC report’ I wonder how it was possible for me to have been satisfied to submit such a thin, uncritical and unreflective report and, even more surprisingly, how this report could have been accepted as satisfactory evidence of learning. Reading ‘Where do I stand?’ offers clues in that the critical and reflective enquiry and examination of pedagogical ‘fit’ that I might have expected to develop and underpin my project was neither offered nor modelled within the TTC program. In examining the institutional, cultural and political contexts of higher education within which my TTC experience took place, the absence of ‘creative or critical intellectual work’ in TTC and in my report are less surprising. Facilitators, participants and planners alike, we were all subject to the neoliberalising educational environment that prioritises economic outcomes (Barnett, 2010; Davies, 2005; Noble, 2002) (which my project ‘product’ could also be seen to support by reducing student attrition from the course) and leads to reduced time (Davies & Bansel, 2005; McInnis, 2000), increased workload (Agbim & Ozanne, 2007; Davies & Bansel, 2005; McInnis, 2000) and restricted opportunity for sustained intellectual endeavour (Coady, 2000). No wonder a thin account of a useful project was considered
satisfactory by a naïve new academic and a facilitator ‘stepping in’ to a program not of her making.

Coady (2000), Davies & Petersen (2005) and others warn that, contrary to the neoliberal rhetoric of the free market producing innovation and creativity through competition, the impact on higher education is to actually reduce the conditions that enable “significant, creative or critical intellectual work” (Davies & Petersen, 2005, p. 78) and support the complex work of intellectual scholarship (Coady, 2000, p. 24). If the limitations of the TTC program, revealed in the tale ‘Where do I stand?’ can be used as an example of a managerial initiative to support and develop expertise in teaching, which is both an economic imperative and a key creative and intellectual endeavour for academics, then these warnings appear well-founded. The institutional culture as shown through TTC, negated the personal in education and applied undifferentiated ‘training’, rather than transformative education (Noble, 2002). It did not build connections and relationships between facilitators, presenters and participants. It ignored existing skills, experiences and teaching challenges of participants. It did not build on what individual participants already knew. The presentation, at Bathurst, of a range of organisationally sanctioned teaching projects, irrespective of their relevance to individual participants, indicates an organisational culture that prescribes teaching ‘products’ (often technical) for the easy adoption of participants and as generic ‘solutions’ to teaching challenges - thus supporting the commodification (Noble, 2002; Olssen & Peters, 2005) and de-contextualisation (Frenk, et al., 2010) of higher education
and ignoring the complexities and ‘messiness’ of actual educative processes with students and teachers (Granger, 2011). Perhaps most telling was the treatment of experienced staff in TTC, who had presumably been recruited for their specific expertise and experience, but who were viewed, interchangeably with inexperienced academics, as subjects for enculturation into institutionally prescribed teaching models, rather than as people bringing, and able to share, diverse and valuable alternative teaching knowledge on which to build the breadth and depth of pedagogical expertise in the organisation. This strongly reflects the de-valuing of academic expertise and replacement with managerial controls described by Deem & Brehony (2005) as the “new managerialism” response to neoliberal enterprises and to the uncertainties of the market paradigm. The power relations of a neoliberal enterprise privileges managerial control over the expert knowledge of academics (Davies & Petersen, 2005; Deem & Brehony, 2005), even when it comes to teaching about teaching, it seems. Professional development of academic teachers, being one level removed from the economic activity of teaching fee-paying students, was not accorded space and time free of the ‘business’ of teaching. These circumstances give context to the dissatisfaction of participants that led to them collectively interrupting the program (the ‘mutiny’) in order to argue for changes to the remaining sessions of TTC.

Barnett (2007), through his ‘pedagogy of care’, suggests how education at the level of individual teaching can continue to thrive within a context of uncertainty and neoliberalisation. His focus is on the nature of relationships
between teacher and student (supportive over time, mutual respect) and fostering in the student a capacity for critical, ethical and reflective enquiry that both frees and engages her mind in both researching the enquiry and discovering more about herself as a learner and practitioner. This type of engagement evokes transformative education (Frenk, et al., 2010) and, as such, may position the student well to live, learn and work effectively and flexibly within conditions of uncertainty. However, this pedagogy did not inform the key professional development opportunity I encountered as a new academic. TTC did not offer such an educative experience for participants, nor did it model transformative education in the content of the presentations or the process of undertaking a project. This was an opportunity lost to all parties, the academic learners, their prospective students and the institution.

It seems that the institutional response to external conditions of uncertainty, that of ‘new managerialism’ (Deem & Brehony, 2005), is entirely unrelated to the recommendations of Barnett (2010) and counter-productive to supporting the sort of transformative education that will enable students, and the people whose lives they will affect as professionals, to thrive. The ‘TTC report’ does not include any educational theory. There is nothing that places the curriculum development within a pedagogical framework or suggests that there are deeper and more troubled and messy issues at play for me to consider in my teaching to meet the needs of my particular cohort of students. It is perhaps strange that, given the emphasis in session one on the teacher/student centric teaching continuum and my stated desire to “better meet the [learning] needs of my
students”, I did not even analyse my project according to this obvious criterion. However, in the context of the TTC program in that particular incarnation, it is perhaps not at all surprising that I failed to even consider my specific learning needs as an inexperienced teacher grappling with the educational needs of a diverse cohort of interdisciplinary students via distance education. Nonetheless, while the TTC program was not conducted Freirean-style ‘under conditions where [our] stories [were] listened to and respected by others’, this did not prevent my colleagues and I from speaking our world in various ways in an effort to improve educational quality; these responses have taught me more about transformative learning than the program itself.

*Individual and collective agency*

I stated in the ‘TTC report’ that: “My hopes in attending TTC were for inspiration and knowledge with which to develop my ability to shape both my teaching within subjects and the course and subject content and resources to better meet the needs of my students.” So it is telling that my report excluded any discussion of my own particular learning needs (as a teaching academic appointed from professional social work practice to specifically teach gerontology to health practitioners) or those of my students. As a reflection of my initial hopes for TTC, this aim foretold of tensions to come wherein my own degree of agency, and that of fellow academics, were to be tested. In the following discussion I critically reflect on my individual efforts to secure the much anticipated quality training as a fresh academic arrived from professional
practice and how this became entangled in a collective response to the institutional pressures I was newly experiencing in an academic context, and yet was to find disappointingly familiar in hindsight.

After re-reading these texts together and examining the context of this learning experience it seems to me that the fragility of my identity as an academic, at the time of this professional development, contributed to my lack of active participation in the process of my own learning. My professional identity issues were compounded by not being located within a strong discipline area with a well-defined identity within the university. Greater certainty of academic identity may have ensured the shortcomings of the TTC program were more easily overcome or at least had less impact on my discipline and students. Given, however, that gerontology, as a new and multi-disciplinary field does not have a strong identity and clear location within higher education (Haley & Zelinski, 2007), and that gerontology at CSU has a small staff group, my difficulties in establishing my own academic identity as a practitioner/academic further hampers the development of a disciplinary identity within my university. This, in turn, has implications for my students, in continuing to render them less visible within the larger cohort of students in the university and restricting the discipline’s power to advocate for their interests. My panicked response to the initial ‘stand within the continuum’ exercise was largely driven by my sense of inadequacy as a ‘real’ academic and obscured what some moments of rational reflection might have reminded me of, such as my practice understanding from working with older people, of the adult
learning principal of education needing to be focused initially on what the learner already knows and move on from there. My practice knowledge therefore inclined me quite strongly towards a student centred approach, as did my focus on the foundational academic learning needs of a group of my students, however, I found myself unable to access or articulate my position at the time. Nonetheless, this focus on my students’ needs did enable me to identify the learning opportunity of most value to me from the smorgasbord of presentations on teaching projects later in the program.

My ‘TTC report’ represents a functionalist and instrumental approach to teaching and the academic role and exposes my lack of pedagogical theory (or even inquiry), despite having ‘graduated’ from the TTC experience. ‘Where do I stand?’, in contrast, highlights the ambivalence and uncertainty that I experienced in becoming an academic, where I felt my practitioner identity to be minimally recognised and my transition to an academic identity seemed highly problematic. My sense of myself in this tale is that of an outsider. My identity as a practitioner had made some space for an academic self to grow but the space fluctuated according to factors such as workload, and the consequent feelings of being overloaded; confidence, or lack of it; the nature and degree of organisational feedback and recognition, or lack thereof. The transition was slow and incomplete because as enunciated by Muncey,

Self is a process not a structure. The process of becoming is always in motion. Any evocation of an experience is always
incomplete and in transition, and at best can only be described as a snapshot (2010, p. 23).

Similarly, Taylor (2006, p. 194) notes that professional identity is not something which exists of itself, unproblematically, and which professionals simply bring with them to their everyday encounters with others. She argues that identity “is closely connected to issues of representation” (p. 194) and is performed in a myriad of specific instances of professional practice. Identity is often represented in reflective accounts of these instances, such as the two texts in this layered account, which convey that

...identity is not a collection of fixed and static attributes that we possess, rather we make our identities in the course of our everyday lives in interaction with others. Within a work environment, we strive to ‘pass’ as a competent practitioner…

(Taylor, 2006, p. 194).

Within this process of fluctuating identity formation these texts can be seen as snapshots taken at different times in my journey towards becoming an academic.

At the time of the TTC program I was not long out of professional practice and my central priority was determining how best to assist experienced practitioners to better serve the needs of older people through the academy. This is reflected in ‘Where do I stand?’, which restores my students to the account, via Julie, whose story shares the characteristics of mature age, fulltime work and family responsibilities along with commitment to working with older people and to her
study with many other gerontology students in the course. The Graduate Certificate in Gerontology offers a very important pathway into higher qualifications and career progression, not just for health professionals with existing degrees but also for a cohort of aged care workers who are among the lowest paid and least valued workers in our community and, as such, face educational disadvantages, which this course has the capacity to overcome. It is vital to find better ways to support these students in their transition to higher education. Although the majority have undergraduate degrees in their professional health discipline and are well equipped to move into the level of study required, those students like Julie, whose experience and passion for their work with older people make them ideal candidates for further education, and to become leaders in their field of practice, deserve support to also be able to take up these opportunities. Julie’s situation is not unlike that of many other students, also highly committed to their work and study in ageing and negotiating work in aged services with family responsibilities and study. Angus (2009) noted similar backgrounds and commitments amongst her students. For those unfamiliar with academic skills or unsophisticated in their online and information technology skills, however, it is a steep and daunting path to even get started in their gerontology learning without first having an opportunity to learn critical study skills. The TTC program, being designed for ‘one size fits all academics’, necessarily negated the diversity in our student cohorts, thereby enacting a faulty managerial assumption that teaching may be a technical process interchangeable amongst students and consistent across widely diverse contexts and content of learning (Davies, 2003; Granger, 2011).
Given my priorities to assist students like Julie, and through them older people, the mutiny which occurred during the Bathurst session created conflicting desires for me. I wanted to hear the particular presentation that happened to be the one interrupted, but also wanted to support the views of the protesting group that the program was not meeting our educational needs well. Locating the events of ‘Where do I stand?’ within the contemporary institutional culture of tertiary education, the central dilemma for me is revealed as the choice of positioning myself either within or against the prevailing, externally directed managerial conditions on offer within the TTC ‘learning’ experience. However, given that I anticipated a synergy between my identified curriculum issue and the disrupted presentation, I was faced with the prospective immediate benefit of the session going ahead being in conflict with my recognition of the collective and individual justification for challenging an educational program which was failing overall to meet the needs of participants, and by extension their students. In re-reading “Where do I stand’, I recognise that my overwhelming commitment was to my students and to accessing the potential benefits of the presentation.

My dilemma reflects a broader problem for academics in relation to taking a position against the prevailing culture of managerialism. Academics have traditionally been seen as critical and feisty in support of their independence and areas of expertise. However, neoliberal conditions (Davies, 2005) and the rise of managerialism (Agbim & Ozanne, 2007; Deem & Brehony, 2005) have
contributes to changes in this culture. For academics to assert their ‘expert knowledge’ (of their own educational and scholarly needs, or of the needs and requirement of their students) is increasingly difficult within a tertiary education system dominated by a version of managerialism that privileges generic standards, audit and assessment and ‘commodifies’ knowledge to meet the needs of the ‘enterprise university’ (Barnett, 2010). This culture also devalues situated, local and specific knowledge (Davies, 2003) and academics are constrained by managerial rewards and sanctions from expressing critique or dissent (Davies, 2003, 2005; Davies & Petersen, 2005) so that academic autonomy and dissent have become problematic. Furthermore, given that the managerial culture works against collegiality amongst individual academics, such as through the TTC format, and between managers and academics and different faculties and disciplines (Davies, 2005; Deem & Brehony, 2005), and that academics are operating within a system-wide pattern of increased workloads (Davies & Bansel, 2005; McInnis, 2000), there is less likelihood of academics being able to organize collegially to critique and improve the diminished conditions of teaching and learning conferred on them and their students by managerial decisions in an enterprise university. Further, there is less opportunity for new academics to receive informal on-the-job learning about pedagogy from more experienced, but time poor, academics, which makes it all the more important for formal programs to be meaningful.

Within this cultural context, the actions of a significant proportion of the TTC participants in disrupting the program to protest against its perceived lack of
relevance and value to them and the receptiveness of the facilitator at this point, which enabled the dissension to be channelled effectively, may be seen as a somewhat unusual and important collegial and dissenting stand. There is an exquisite irony in this group of teachers-as-learners taking such a stand, endorsing by their actions the need for student-centred teaching, within a program that had begun by attempting to examine this pedagogical approach, through a format and structure which actually negated it. However, the silencing within the TTC program of participants, their students, and the facilitators, as previously noted, was overcome by a collegial response to individual experiences of frustration and anger. The outcomes of the dissension well have been far-reaching. The nature of staff orientation and academic teacher education at this university has been substantially redeveloped since this program. This event shows the academic participants resisting organisationally sanctioned learning experiences that failed to meet their needs and in so doing, expressing their own agency. This may well have been possible due to the low potential for sanctions against dissent within this program whereas individual or collegial agency may be far more difficult where organisational sanctions, such as rejection of promotion applications, can be applied. Nevertheless, the mutiny demonstrated the power and necessity of collective agency to bring about institutional change. Paralleling the comparatively weak professional organisation of gerontology practitioners compared to nurses, for example, gerontology educators are similarly disadvantaged in the academy compared to disciplines with a strong sense of collective identity and coordination. This layered account underscores the
imperative for gerontology educators to better organise as a group if Frenk et al.’s (2010) call to action is to be answered, but it does so in a way that fleshes out the nuances and difficulties of educational practice in the current institutional climate.

Conclusion

I chose my experiences of the TTC program as a vehicle to ‘speak my world’ in this layered account partly because they represent a period of transition – moving into the role of a teaching academic and, in so doing, developing another version of my professional identity. My expectations of academia were centred on a rosy picture of being able to combine my practice knowledge and motivation with university resources of time and guidance in scholarship, in order to apply creativity and intellectual rigour to my teaching and curriculum development roles. The impacts of neoliberalisation and new managerialism in higher education were not fully known to me at the time. Needless to say, my expectations of learning how to facilitate transformative education that ultimately assists older people have not yet been fully realised.

Similar expectations about the power and potential of health practitioners and academics appear to inform the Frenk et al., (2010) call to action and Barnett’s urgings for a caring pedagogy (Barnett, 2007), however they offer little insight into how this is to be achieved within the current institutional constraints as they are experienced at the health and educational coalface. The predominant
political and cultural influence on tertiary education and public healthcare over the past decades has been neoliberalisation, which has reduced government regulation and funding and exposed them to market forces to shape their ‘business’ of teaching, research and wellbeing (Agbim & Ozanne, 2007; Barnett, 2010; McInnis, 2000). In the case of universities, this has caused them to adopt features associated with the “enterprise university” (Marginson & Considine, 2000) and the “entrepreneurial university (Etzkowitz, et al., 2000), such as tight executive controls, competition, education as a commodity and the development and privileging of financially profitable courses and knowledge tasks. Universities in this cultural and political context have necessarily moved away from what Ekstrand (2013) argues is one of the most important goals of education – that of building knowledge for the common good of society, and moved instead towards pursuing economic goals. The nature of my TTC educational experience can be understood within this context.

The tale ‘Where do I stand?’ revolves around my entanglement in what I have called a ‘mutiny’ against these forces. Issues of institutional culture, power and control are highlighted in relation to my experience as an academic undergoing in-service teacher training through the TTC program, wherein the planned educative program failed to engage and meet the needs of academic participants who ultimately took collegial action to resist the program. The pedagogical issue that opens the tale, student-centred versus teacher-centred teaching and learning is also highlighted at a number of levels and the institutional context is examined to provide a backdrop and analysis of the events and experiences
represented in the tale. It depicts events, and my experience of them, which were not acknowledged in the ‘TTC report’ and which, on examination in relation to literature on the cultural contexts of tertiary education, offer alternative versions of the experience of academic teaching and learning and a richer learning experience for me than the TTC program itself generated at the time.

Together Chapters Four and Five speak of how my world as an advocate for older people both intersects with, and disconnects from, their world. It is essentially about this relationship as I am experiencing it, which may in turn illuminate the worlds of others already in, or contemplating starting, similar relationships. For example, as Agbim & Ozanne (2007) note, the impact of neoliberal policies and managerialism is felt similarly within the organisations in which the aged care and health practitioners who are gerontology students work, hence my exploration of the impact of these contexts on my experiences of professional development as a teaching academic may potentially bear relevance to the experiences of my students of professional development within their organizations. Further, the centrality of transformative education, and the difficulties of building it, point to areas of professional coordination and collaboration that warrant closer attention.
CHAPTER SIX: CONCLUSION

Introduction

In answering the research question – what are an academic’s experiences of teaching gerontology to diverse practitioners in Australia and how can these experiences contribute to the potential for transformative education in gerontology for health professionals – this thesis has investigated my ‘coming of age’ as a gerontology educator and the ‘coming of age’ that is needed of the gerontology education community. This concluding chapter brings these themes together in a discussion of the original substantive and methodological contribution of the thesis. It then underscores the key findings of the study as a basis for reflecting on its social implications. Lastly, several possible lines of future research are proposed.

Original contribution to gerontology education

This study makes an original contribution to the under-developed field of gerontology education in Australia in several ways (Coles, et al., 2013). Substantively, it offers insights into gerontology education and health practice with implications for public policy development and educational arrangements. It does so through a case-study of an academic’s experiences in teaching
gerontology to diverse health practitioners within a regional Australian university and an examination of the current nature, state and context of gerontology education. Methodologically, it uniquely applies autoethnography to offer a rare health and educational practitioner’s standpoint to the existing scholarship on gerontology education, which it is argued is crucial to building an effective response to current ageing, health and educational challenges.

To date, there have been two brief articles offering overviews of gerontology education in Australia (Coles, et al., 2013; Howe, 1990). This examination builds on these through increased understanding of the requirements for gerontology education to be able to contribute to improved health and equity for older people and of the structural barriers to its development. For example, the study offers analysis of cultural and institutional contexts of teaching gerontology within the current neoliberal political culture, academic and managerial cultures of the university and health professional cultures of knowledge for practice in Australia. This analysis is developed in dialogue with critical reflection on my individual experience of negotiating these cultures in pursuit of a commitment to teaching gerontology and a motivation to develop transformative education for gerontology practitioners. Reporting from the EHP Commission, Frenk, et al. (2010) note the scarcity of education in this broader field and makes a strong call for the development of transformative education to produce agents of change able to improve health, reduce health inequalities and support social justice. This call is highly relevant to gerontology professional practitioners who work with a vulnerable group of older people,
many of whom are subject to ageism and marginalisation in the health sector and other areas of their lives. Hence, the study links a micro level examination of my personal practice to macro level critiques of gerontology education and links both to implications for gerontology student experience, curriculum, teaching and transformative education in an innovative, reflective and critical account.

Findings from the study suggest action to develop gerontology education for health practitioners in Australia. For example, the importance of cooperation across the health and educational spheres seems paramount if transformative approaches to gerontology practice are to be established. One pathway that currently links the two groups of professionals is postgraduate gerontology education. Yet, despite a substantial and growing gerontology research capacity (Australian Association of Gerontology, 2014a) and output in Australia and an active national organisation, the AAG (2014c), that links researchers and aims to promote gerontology education through dissemination of the findings from research in seminars, conferences and now, online webinars, there is little published scholarly work on postgraduate gerontology education for health practitioners and no formal established network of educators nationally across universities. This is despite the context of population ageing, projected growth of demand for health services and care by older people and an under-resourced and inefficient aged care sector (Productivity Commission, 2011). International literature on gerontology education is more extensive but there is also little focus on postgraduate curriculum or investigation into what is currently being
taught in gerontology education (Sterns & Ferraro, 2008) and even less known about the current situation in Australia (Coles, et al., 2013). Greater attention to the breadth of educational and collaborative experience at this level is a valuable place from which to build a community of transformative practice and scholarship.

This examination invites the building of such a community by sharing a critical engagement about lived realities at the health and educational coalface of gerontology. Previously, there has been no scholarly examination of the experiences of a gerontology academic in Australia and the autoethnographic methodology that enables a focus simultaneously on the individual experiences and the political, social and cultural contexts of gerontology is original and offers insights and provokes questions at both the micro and macro level. The study uses an autoethnographic methodology of layered accounts (Denshire, 2014) for the first time in this field, taking as a basis for examination two pairs of texts about gerontology practice and education, that I have written in chronologically and stylistically different contexts. One of each pair is a text written some years previously (in pre and early academic practice respectively) and the other is a linked tale, written for the purposes of this study, focusing on gaps in the original text to reveal previously untold stories of my practice which create starting points for wider examination of the field (Granger, 2011). While autoethnographic research is developing in education (eg. Granger, 2011; Muncey, 2010; Peseta, 2005) and layered accounts have been used to examine professional practice and development of identity (Denshire, 2009), this is a
novel use of the method in the field of gerontology education. Through the layered accounts method the study uses writing as enquiry (Richardson & Adams St. Pierre, 2000) as a creative way of reflecting on practice in an original application to gerontology education. The multi-level method is well-matched to meet the urgent need to open up this important field to initial exploration and as a starting point from which to develop future research questions and possibilities for collaborative action.

Key findings

In telling this story of gerontology education in Australia the thesis in the first chapter introduces and examines the social, demographic and policy context of health and care services for ageing Australians (eg. Attorney General's Department, 2010; Australian Institute of Health and Welfare, 2007; Betts, 2014; Business Council of Australia, 2013; Family and Community Development Committee, 2012; Productivity Commission, 2011). It establishes a strong case that there is an urgent and growing need for specialist gerontology-trained health professionals (Aged Care Workforce Committee, 2005; Australian Government Department of Health and Ageing, 2012; Productivity Commission, 2011; Russell, et al., 2007), within the context of an ageing population, to not only provide expert and professional services to older people but also to provide leadership in policy and service development and advocacy for the needs and interests of the ageing population (Angus, 2009; CFHCWOA, 2008; Frenk, et al., 2010). A substantial disconnect is
demonstrated between the urgency and importance of this need for gerontology trained health professionals and the lack of development of this issue in national research, enacted policy and resourcing and the lack of information about and cohesion within gerontology education (Coles, et al., 2013). Ageism (Angus & Reeve, 2006; Eymard & Douglas, 2012; Harper, 2006), misinformation (Coory, 2004) and lack of clarity about the future impacts of the ageing problem continue to create a misplaced ‘crisis of ageing’ discourse (Betts, 2014; Healy, 2004; Martin, et al., 2009; Poole, 2014), that while fuelling uncertainty (Healy, 2004; Martin, et al., 2009) poses a barrier to informed and reasoned debate that might lead to development of coherent, effective and socially just policy to enable appropriate adaptations to an older population structure (Betts, 2014; COTA Australia, 2014; Ingles & Denniss, 2014).

A significant gap in the literature in relation to gerontology education is revealed in Chapter Two. This is particularly evident at the level of addressing issues around transformative education and is of critical significance if gerontology education is to produce gerontologists who are not only expert in the field and ethical professionals, but will also be able to act as agents of change (Frenk, et al., 2010) to improve social justice and health equity for older people in this time of widespread challenge and opportunity associated with population ageing (Harper, 2006) and continuing ageism (Angus & Reeve, 2006). Examination of the neoliberal context in which education and health systems currently operate indicates that gerontology will continue to face substantial structural obstacles to developing transformative education.
Obstacles include the difficulty of a new and interdisciplinary field in gaining traction within the academy, when the incentives and barriers of managerial culture under neoliberalism favour disciplines with established power bases, existing faculty power structures and professional employment outcomes for students that offer high income potential. Gerontology has none of these advantages and this situation is likely to worsen should proposed Coalition Government changes to tertiary education funding that will require universities to charge higher fees for courses (Hockey, 2014) be implemented. However, Frenk, et al. (2010) pay little attention to such institutional difficulties in their analysis, instead suggesting health professionals ‘complacency’ as a reason for inaction. This is a weakness in their argument. Frenk, et al. (2010) outline some key elements of a transformative education, noting that it is about leadership for change (p. 1952) and includes research, analysis and synthesis of information for decision-making, interdisciplinary competencies and creative and critical adaption of global resources to local contexts (p. 1924). Leadership incorporating management and ethical practice dimensions is identified by Aberdeen & Angus (2005) and Angus (2009) as critical elements of gerontology curriculum for health professionals in dementia care contexts and would seem equally critical in all fields of gerontology and a central element of transformative education. Other elements that may be of vital importance to transformative education include pedagogical relationships of care (Barnett, 2007), a ‘disorienting dilemma’ as a catalyst for change, critical reflection, purposeful relationships with others, more comprehensive ways of knowing, appreciation of context, valuing participants as active shapers of learning, and
ethical responsibilities and sensitivity (Hutchings, 2010, p. 5). Along with the schema endorsed by Frenk, et al. (2010) of informative (producing experts), formative (producing professionals) and transformative (producing expert professional agents of change) education, similar and complementary models of curriculum for practice (Barnett & Coate, 2005) (knowing, acting, being), of professional practice knowledge (Titchen & Higgs, 2001) (propositional, professional craft and personal) knowledge, and (Hutchings, 2010) (head, hand, heart) knowledge, provide a beginning framework through which to examine and develop practitioner knowledge towards transformative learning. However, given the absence of gerontology education literature, and especially literature that includes educators, students and older people’s voices, the current level of development of gerontology education in Australia is not accessible to comprehensive assessment and therefore it is not yet possible to chart a course toward achieving transformative education and the subsequent positive health changes sought by Frenk, et al. (2010). It is necessary to first understand what gerontology educators are currently doing and how they are working to achieve transformative goals and surmount the barriers. This thesis makes a single case study contribution to that end.

In Chapter Three the selected methodology is introduced and the case is made that autoethnography offers an appropriate method through which to examine the research question. Autoethnography suits exploratory study of a field, such as gerontology education for health practitioners in Australia, that is hitherto underdeveloped and lacking a strong published body of work. Autoethnography
is also well-suited to study of education (Ellis, et al., 2011; Granger, 2011; Muncey, 2010) and professional practice (Denshire, 2014; Denshire, 2009; Peseta, 2005) and has the benefit of generating questions and insights at both micro and macro levels of the issue under study, enabling examination of both the local and individual condition as well as the broader cultural context in which the individual experience is situated and shaped. The particular method of layered accounts is outlined and the process used in the study explained. Autoethnography does not seek to generate a single unchallengeable truth or reality but to illuminate a single instance within a cultural context that offers new, transgressive or alternative views of an issue or field (Chang, 2008; Ellis, et al., 2011; Granger, 2011; Muncey, 2010). Application to wider contexts is realizable in terms of the insights, questions or ideas evoked in the reader about her own concerns beyond those of the research.

Chapters Four and Five explore instances of my professional and academic practice experience through the method of layered accounts. ‘Speaking their world’ (Chapter Four) examines my writing about the Healthy & Wise program and reveals this to be a practice based example of transformative education for me as the knowing, doing and being; the head, hand and heart; the informative and formative meshed for me within this practice to change my understanding of working with older people in partnership. The tale, ‘Wonderful, brave, together’ reveals, not unproblematic, but ultimately mutually empowering relationships between different participants and between myself as practitioner and participants. It suggests the transformative power of this educative
experience for several of the women. I argue in this chapter that the elements of transformative education as outlined by Hutchings (2010) (ie. a dilemma or risk as catalyst for change, purposeful relationships, collaboration, critical reflection, appreciation of context, valuing participants as active shapers of their learning and ethical responsibilities and sensitivities) were experienced within the program for several participants who demonstrated significant changes in their attitudes and/or life. This reinforces for me the value of Hutchings’ (2010) work as a basis for further pursuing transformative education in partnership with students.

The tale also reveals the power of older women speaking their worlds in pursuit of health and wellbeing. It shows older women resisting not just the stigma and culturally created shame of speaking about their depression and the issues that caused them pain but also resisting the silencing of older people (in particular women) by ageist community attitudes (Angus & Reeve, 2006; Cruikshank, 2006; Hooyman & Kiyak, 2011; Martin, et al., 2009) and ageism present in health services (Angus & Reeve, 2006; Eymard & Douglas, 2012). These women actively participated together and with me as facilitator in dealing with their challenges and promoting their wellbeing. I present this as important work.

This study contributes to my belief that this work (and many other examples of effective practice being enacted on a daily basis by health practitioners) offers significant scope for my own learning, and may also bear relevance to wider
mental health and health promotion contexts. A key finding of this chapter, however, is that the culturally sanctioned forms of professional and academic writing cannot tell the whole story of ‘messy’ practice that involves complex human interactions. Traditional professional and academic writing privileges bio-medical knowledge, positivist research as evidence and provider-centric perspectives and while these are all important and valid aspects of the knowledge practitioners require, the bits of the story left out tend to be those that might represent older people ‘speaking their worlds’ and practitioners likewise representing their work as alternative forms of evidence (Titchen & Higgs, 2001; Labonte, 2007). The silencing of these perspectives leaves us with critical gaps in how and what we can learn from practice in service of transformative education.

This is not to suggest that biomedical and scientific knowledge, traditionally reported, is not of significance, it is clearly of vital importance, especially in developing knowledge of health conditions in ageing and effective treatments. I argue, however, that in gerontology education we need to find additional ways to recognize, represent and learn from a broader range of evidence about local and everyday health practice. Labonte (2007) illuminates this point in arguing that, whereas conventional science and positivist research is concerned with the establishment of truth, research using narrative methods aims to provide meaning. There is scope, then, to challenge the narrow view of evidence and reporting (Titchen & Higgs, 2001) in order to expand the space to include thoughtful forms of practitioner knowledge, based in robust reflexivity and
using critical faculties as both an instrument and outcome of transformative education to enable gerontology students to become agents of change in their practice. A key question raised by this discussion, which was further examined in Chapter Five, is how this may be able to be achieved within health and academic cultures that are dominated by marketised neoliberal conditions?

Chapter Five, ‘Speaking my world’, focuses on my experiences, as a new academic, of professional development in teaching. It exposes the mismatch between my motivations in joining academia, and expectations of how my role in enacting transformative education would be supported within the institution, and the reality of joining a tertiary education sector dominated by market-driven neoliberalised structures, policies and relationships. The tale of my teaching professional development program (TTC) reveals a personal dilemma about where to stand in relation to several critical issues. Taking a stand on student-centred versus teacher-centred education began the tale, however, as events unfolded, the requirement to take a stand revolved around a collective challenge to a program that failed to meet participants needs (that was not of itself student-centred) that risked the cancellation of a single aspect of the program that I could see as being of value to my students. While I did not speak up during that event the analysis of it makes it clearer to me where I stand. Speaking my world of gerontology education involves advocacy for my students and the older people with whom they work. This is a central concern of my professional practice and teaching and an overarching theme of these chapters. A key finding is the challenge posed to this work through the power
of managerialism and the current market driven and neoliberalised context of both health services and, particularly, academia (Agbim & Ozanne, 2007), that is, within the work context of both my students in practice and of myself as teacher. The power of this political ideology enshrined in health and education institutions in the form of reduced resources (Agbim & Ozanne, 2007), increased workloads (Davies & Bansel, 2005; McInnis, 2000) and silencing of professional and expert voices and dissent (Davies, 2003; Deem & Brehony, 2005) is not addressed by either Frenk, et al. (2010) in their call for transformative education or Barnett (2007) in his pedagogy of care. The example of collective collegial action to disrupt the TTC and, in partnership with the facilitator, negotiate alternative arrangements for a more relevant educational experience, provides an indicator of a more general way forward in standing together collegially to effect change.

In summarising the findings of this study, a key challenge for me as a gerontology educator working towards transformative education is to develop pedagogy and spaces for learning that echo the work of Hutchings (2010) and Barnett (2007), particularly in developing collegial relationships and interdisciplinary teamwork between students and exercising a mutually engaged pedagogy of care within the distance education online mode. To support the development of graduates as both ethical leaders (Angus, 2009) and agents of change (Frenk et al., 2010) capable of operating within conditions of change and uncertainty (Barnett, 2007) key challenges will include equipping them with robust processes for critical reflection on their practice and critical analysis
of policy. There is a need to broadly challenge traditional language and forms of representation of practice that obscure the voices and multiple knowledges of the practitioner and restrict them from eliciting and representing the voices of the older people with whom they work. Practitioners able to identify their multiple forms of practice knowledge within a process of critical reflexivity may be more open to and able to translate new research knowledge into practice. Another critical challenge will be to assist gerontology practitioners to learn the skills of critiquing not just policy and practice but also the institutional and political structures that place barriers on the development of equitable and socially just health and education practices. It will be important to begin to build a national collective voice to represent gerontology education and enable further examination of both the current state of play in Australia and future development to enable the transformation of health services and opportunities for older Australians.

**Implications and future research possibilities**

This thesis has identified gaps in research on gerontology education of health professionals that requires substantial attention. In revealing my experiences, as one educator, within the current cultural and institutional contexts of gerontology education, I hope to have provided a story that generates further questions for the reader about how to develop this field to meet the needs of an ageing population through transformative education. As a result of this study, I will be seeking new ways to develop the online distance education experience
to be more interactive and collegial between students and finding ways to develop capacities for interdisciplinary teamwork within the curriculum. Future research could usefully identify and survey gerontology educators in Australian universities in order to understand the state and sufficiency of gerontology education to meet future challenges, thus generating the possibility of multiple fruitful further research questions. Research endeavours that promote collegial approaches by gerontology educators across institutions and jointly with gerontology practitioners in health service settings will also be important to build collective capacity to advocate for this important field of education.

Conclusion

The thesis makes an original contribution to the field of gerontology education which is hitherto under-developed in Australia through a critical exploration of the singular experiences of a gerontology educator within an analysis of the cultural and institutional contexts of health professional practice and academia, using the novel methodology of autoethnography. It seeks to represent one version of the lived realities of practice and academic life as an original way of opening up the field of gerontology education to a critical gaze and uses the schema of Frenk, et al. (2010) to explore transformative education. Key findings include the apparent mismatch between the growing need for gerontology educated health practitioners in the context of an ageing population and the lack of formal research, policy or resources being directed to this issue. The call made by Frenk, et al. (2010) for practitioners as agents of change able
to work towards improved and equitable health outcomes and social justice, in this case for vulnerable older people, is not yet being heard. Robust processes of critical reflection and skills to critique practice, policy and institutional and political constraints learned within collegial relationships between students and student and teacher are amongst key elements of a transformative education to be further developed in gerontology education. Challenging the dominance of traditional representations of practice that emphasize biomedical and informative knowledge in order to make space for representations of practice that show complex multiple practitioner knowledge will be an important development in building transformative education. There is a need to build a collective national voice of gerontology educators in order to further research this important field and advocate for development of gerontology education to meet the health needs of older people in the future.
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Healthy and Wise: the process of planning a mental health promotion program.

“Health promotion is a developing ‘art-science’ involving processes of individual, social and environmental change as well as health sciences content.” (Egger, Spark and Donovan, 2005)

Introduction

This article will document, from the perspective of the project worker, the process of development of the Healthy and Wise Program in 1998. Healthy and Wise is a health promotion program aimed at reducing the risk of depression for older adult participants.

It begins by briefly outlining the program and its history. The concept of ‘wellness’ will be examined and the working definition of health promotion used in the project outlined. The rationale for addressing the issue of older age depression through this health promotion activity will be explained, using evidence from the literature and research on the value of health promotion strategies in building wellness.

This paper will provide a case example of the ‘developing art-science’ of health promotion referred to in the opening quotation as, in the absence of similar programs for guidance, I found myself enacting an idiosyncratic model of planning for health promotion. The process was informed by practice models from fields other than health promotion, including adult education, group dynamics, community development, action research and narrative approaches. The Healthy and Wise program targets individual change through health education and personal support while the development phase also aimed to effect community education and awareness of the issue of depression and promotion of positive mental health in older people.

An Outline of the Healthy and Wise Program

The Healthy and Wise program is an eight session small group program for people aged 50 years and over which uses a broad “four way fitness” framework to promote health and wellbeing. Four way fitness involves physical, mind, social and purpose fitness (concept adapted from Birren and Deutchmann 1991). The format is a mixture of information and opportunities for exploration and discussion and the content of the program may be adapted to suit the particular interests/needs of the group.

Topics include dealing with change, stress and relaxation, memory and depression, communication, assertiveness, gentle exercise, loss and grief,
spirituality and enjoying your age. Two of the sessions are held as public sessions to increase the number of people benefiting from the primarily information focus. These deal with physical health issues “in partnership” with health providers, and legal and financial issues.

The program content was developed in consultation with community groups and, through detailed interviews with older “mentors” whose themes of wellness and coping with difficulties influenced the content.

The program is implemented in conjunction with local health services and advertised widely to the public as well as through health services. It is suitable for older people experiencing mild to moderate depression or stress as well as those keen to maintain their health and wellbeing. Positive group dynamics builds new social supports amongst participants.

Evaluation of the program is carried out using the Geriatric Depression Scale (Sheik and Yesavage, 1986) a 15 point self-rating questionnaire which is administered in the first and final sessions to measure improvement in wellbeing by it’s inverse. The GDS is also useful in early identification of any participant who may be in need of individual or further assistance due to serious depression.

The initial series of programs were independently evaluated by Suzy Gattuso, of Charles Sturt University’s Rural Lifestyle and Aging Group. (Gattuso, 1999) Using the GDS, Suzy found a significant improvement in wellbeing of participants between pre-and post test which was maintained at 6 month follow-up. Qualitative feedback from participants supported this finding. (Appendix 1, Summary of Gattuso’s Findings, Harvey, 1999)

The program has since been published as a resource package for health practitioners, to increase access to the program.

**Program Rationale and History**

The project was initiated by the Aged Psychiatry Service (APS) in north-east Victoria. The APS manager identified a high level of referrals of people suffering from depression associated with the personal or social/environmental situation in which they found themselves as a result of normal transitions of aging. These referrals were being received at a late stage in the development of the depression and at a point where the older people concerned had already suffered considerable distress and disruption to their lives and those of their families (Davidson, 1997).

These observations led to a focus on the potential for health promotion activities to engage personal adjustment factors in order to prevent depression and promote positive mental health among older people.

I was appointed as the project worker in April, 1998 and given the brief to:
“develop, implement and evaluate a group based education/information package for older people, in consultation with other relevant service providers and with older people in the community” (Davidson, 1997).

While the brief was already established and the choices already made to develop a health promotion activity based on a small group health education program, the particular strategies and processes by which to achieve this were undetermined.

**Definition of Health Promotion**

“Health Promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and realise aspirations, to satisfy needs and to change or cope with the environment” (Ottawa Charter, World Health Organisation, 1986, cited in Hawe, Degeling and Hall, 1993).

Within this definition, there exists the opportunity to focus health promotion activity on any of a broad range of factors including the person’s health behaviours, and the social and environmental factors impacting on the health of particular individuals or communities. This definition emphasises the need to enable people to increase their ability to control and improve their own health. The project focussed primarily on the individual level and sought to promote personal responsibility and control of own health through the provision of relevant information to individuals and community groups, together with the promotion of self-esteem and the ability to be an assertive partner with health service providers in the pursuit of health and well-being.

Explicit in the Ottawa Charter definition is also the challenge to address issues of control over health factors at the level of community, social and policy change to address the inequalities of social, economic and environmental factors which impact on the health of individuals and communities.

This offered the impetus to look for ways to achieve improved health conditions at a community level. The process of developing the program was seen as an opportunity for addressing mental health promotion at the community level by involving a wide range of community groups in the consultative process. A significant part of the consultative process served to stimulate interest in the issue of depression in later life, to provide information of how to recognize and treat depression and to directly pose the questions of ‘what makes for wellness as we age?’

My aim was to enact a secondary focus on the development of community awareness of issues of wellbeing and depression in later life.

**Wellbeing**
While the project sought to prevent depression and the project brief spoke of education about bereavement, losses, stress, anxiety; resolution of conflicts, issues of concern; all problem oriented terms (Davidson, 1997), the real task was to help people build and maintain wellness in order to avoid those problems.

Wellness is a positive concept, not just an absence of ill-health. What makes for wellness in the context of aging? Wellness is a broad term which can encompass a range of influences and factors. Economic security, social supports, enjoyable leisure, family wellbeing, good relationships, an optimistic outlook, a friend to talk to, a sense of meaning and of being useful….all these things and more, as well as good physical health can contribute to wellness. The concept has different meaning to different people.

In order to explore wellness more fully I developed the strategy of recruiting volunteer “mentors” to the project, whom I interviewed in depth about their perceptions of wellbeing and their understandings of what supported their wellbeing, particularly through times of trial. Their information was crucial to establishing the content of the program.

**Depression in older age / examining the need**

Current estimates of prevalence of depression in the general population are that 1 in 4 women and 1 in 6 men will experience depression at some time in their lives (Beyond Blue National Depression Initiative, 2006).

Depression was identified by the auspice agency as a significant problem for older people in it’s community, based on the agency’s own referral statistics and the professional judgment of the team of psychiatric service practitioners (Davidson, 1997).

Further evidence on which the program was based included that from the Australian Institute of Health and Welfare that “Psychiatric disorders are currently the sixth highest cause of moderate to severe handicap and disability in people over the age of 65” (Australian Institute of Health and Welfare, 1998). Estimates of incidence of depression amongst older people living in the community varied considerably, in part perhaps due to the different diagnostic definitions used in different studies. A study by Kay et al. (1988) in Hobart amongst people aged 70 plus, found the incidence of depression as: 16% suffered from pervasive depression, 10.2% from major depression (DSM111), while 19% had dysthymic symptoms. In contrast, Henderson et al., in a study of people aged 70 plus in Canberra in 1993, found that 0.4% of those studied had major depression (DSM 111R), 0.6% had dysthymia (DSM 111R) and 2.9% had experienced depressive episodes (ICD 10). (both studies cited by Snowdon in Chiu and Ames, 1994).
It seemed likely that the number of people in this age group who experience symptoms of depression of a severity which has a significant impact on their ability to function and enjoy life is much higher than indicated either by studies using restrictive criteria based on the DSM criteria or than is demonstrated by the number of people who receive treatment.

Evidence for this locally, was found in the fact that most people referred to the APS for depression had been suffering from significant depressive symptoms for considerable time before being actively treated for the condition by their General Practitioners. Whether this was because of a reluctance on the part of older patients to admit to symptoms of depression or difficulty on the part of GP’s in differentiating depression in older people is not known. The APS at this time was actively training local GP’s in the identification and treatment of late life depression in an innovative onsite training program, which has since increased the early referral of older people with depression to APS (Davidson, 2006).

More recently, Haber, taking an American perspective, comments that “Detection of depression is hampered not only by the under-reporting of symptoms by older patients, but by biases on the part of physicians and family members. In one study, 75% of physicians thought that depression was understandable in older persons, that is, a normal facet of old age (Gallo et al, 1999 cited in Haber, 2003). Family members may also view the signs and symptoms of depression as “normal aging”, when in fact the persistence of depressive symptoms is not normal” (Haber, 2003).

While estimates of depression were questionable, further evidence of the importance of depression as a health issue for older people in Australia, was sourced from Snowdon in Chiu and Ames, 1994, who stated that depression accounted for half of admissions of older people to inpatient psychiatric facilities in Australia and that the length of stay of people with depression is longer that of other diagnostic groups. Depression in older persons, therefore, creates a significant burden on our acute psychiatric services.

The relationship between depression and physical illness in older people is both complex and significant, with the presence of depression in an older person predicting a higher rate of failure to recover from other medical conditions, and depression often predicting and may precede the development of physical disability (Chiu 1999).

McCallum, 1986 (cited by Browning, Wells and Joyce, in Minichello and Coulson, 2005) proposes that transitions of later life may lead to adjustment difficulties, which in turn can trigger depression, whereas, Carstenson, 1992 (cited by Browning, Wells and Joyce in Minichello and Coulson, 2005) argues that “wellbeing may improve in old age due to better regulation of emotions as we grow older”.

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While the prevalence of depression in older people is not clearly determined the significance of depression amongst older people as both a source of personal illness and distress and as a source of social and economic burden within our community is confirmed. (Snowdon in Chiu and Ames, 1994). Population aging in Australia (Australian Bureau of Statistics 2006) indicates that the degree of burden represented by later-life depression will increase significantly.

“Intervention to modify (where possible), risk factors among the elderly for depression could contribute substantially to more successful aging. This task devolves on governments and the community, not just on our psycho-geriatric services.” (Snowdon in Chiu and Ames, 1994).

**Targetting the Program**

We chose a primary prevention strategy, using a general target group of older people (those aged 50’s and upward), a milestone health promotion target (Bloom, 1968 cited in Heller et al, 1996).

The most significant correlates of depression in older people are functional disability, chronic illness, lack of social support, bereavement and other losses, low income and cognitive impairment (Snowden in Chiu and Ames, 1994). These risk factors are common across the older population therefore a broadly targeted approach is required.

**The Value of Health Promotion Strategies in Building Wellness**

My initial literature search for examples of successful programs on which I could model this intervention found little information specifically on health promotion with older people and none directly targeting depression.

Process notes at the time include the following quote from Teshuva et al. (1994) “Nearly all commentators on health promotion for older people have emphasized the virtual absence of information on the effectiveness of interventions…..In addition to identifying the impacts of programs, it is important to understand factors which lead individuals to become involved and to stay involved with them; and to understand the processes and influences on the successful development and implementation of interventions.”

This quote influenced my planning in several ways. First, it led me to move on from looking for the established and proven “recipe” which might guide my efforts, as the lack of available evidence on the effectiveness of interventions with older people clearly meant that I needed to develop my own strategies. Secondly, it led me to recognise the need for evaluation, not just of outcomes of the intervention but also of the “processes and influences on the successful development and implementation of interventions” (Teshuva et al 1994).

The health education model, to which this project was already committed by its initial brief has been criticised as being ineffective or of limited success, in
that knowledge about what influences health does not necessarily cause a change in health behaviour (Egger, Spark and Donovan, 2005). However, health education in the context of peer discussion, using adult education approaches and carefully managing group dynamics offers a potentially effective approach (Egger, Spark and Donovan, 2005).

Since 1998, the literature and practice of health promotion has burgeoned in the area of depression, as it has been increasingly recognised as a major health issue. (eg. VicHealth 2001; National Mental Health Strategy, 2000).

“Social connectedness” has been established as a key factor in mental health and health promotion programs have been developed to address this issue (VicHealth, 2001, 2006) Exercise has been increasingly researched and promoted as being effective in treating depression and improving mental health in older people, although the research outcomes are not conclusive, according to O’Brien-Cousins and Horne 1999).

The subsequent evaluation of the Healthy and Wise program (Gattuso, 1999) is also direct evidence of the value of health promotion strategies in building wellbeing.

Models of Health Promotion

Galbally’s Integrated Model of health promotion planning, 1992 (cited in O’Connor-Fleming and Parker, 2001), would have been a useful tool to have had available in developing the program. This model identifies “4 principles of planning

- identification of the health status and health promotion needs of a population sub-group
- matching of the sub-group with relevant health promotion programs and the adoption of an appropriate methodological approach for achieving the goals and targets of the program
- recognition of key settings for intersectoral implementation of interventions for organizational change
- evaluation throughout for adjustment and change in order to assess final process and outcome results.” (O’Connor-Fleming and Parker, 2001)

I was certainly trying to match my sub-group of older people with an appropriate methodological approach, however this model, while supporting the validity of “horses for courses” rather than “one size fits all” did not suggest any appropriate methodologies. The methodologies which I used to guide my planning for this program included participatory action research techniques (Stringer, 1996), which informed my community consultation process and ensured a reflexive process; narrative techniques (White, 1990, 1995) which informed my exploration of the expert knowledge held by people authoring their own stories of wellbeing; and adult education approaches, “Because adults have lived for and experienced a given number of years they have had the opportunity to gain many perceptions of their environment and the objects and events in it. An adults past experience then forms the basis from which
education and behaviour change must commence” (Egger, Spark and Donovan, 2005).

Galbally’s model refers to the need to recognise settings where organisational change can be implemented. (cited in O’Connor-Fleming and Parker, 2001). Within the process of development of this program, I identified a wide range of older people’s organisations, professional health services for older people and community groups who became part of my community for consultation. These groups were, simultaneously, consulted about the project, prompted to think about wellbeing and also educated about depression. In particular, this educational effort was directed to some of the health professionals, whose advice to me was somewhat ageist, in order to improve their understanding of factors influencing wellbeing in older people.

In this way it was hoped to build into the project scope for development of community awareness and professional education, if not organisational change, as suggested by Galbally (cited in O’Connor-Fleming and Parker, 2001). In this way, my work would be informed by the community’s knowledge and it’s knowledge informed by my enquiry, creating a reflexive partnership in improving the ability of a range of people in the community to understand the nature of depression and extend their ability to resolve risk issues associated with depression for themselves and other older people.

The final step in Galbally’s model calls for “evaluation throughout for adjustment and change” (cited in O’Connor- Fleming and Parker, 2001). While I sought to continually reflect on my process and this led me to adjustments along the way of developing this program, I cannot claim to have evaluated the process in a thorough sense. The outcomes of the Healthy and Wise group program were evaluated (Gattuso, 1999), but the outcomes of the community consultation/awareness process were not.

If community awareness of the issues can be judged, in part, by the participation response to the first programs then something was achieved because the first two programs filled up fast, a third was scheduled specifically to accommodate members of a particular group with whom I had had contact in the developmental phase and a waiting list was started which ensured the program was repeated soon after. The program has continued to run and is still being offered currently, with strong participation.

Conclusion

In this paper I have attempted to document a particular process of planning a health promotion activity related to depression in older adults. It is both the record of an actual process, using contemporaneous notes for validity, and also a commentary on the process, using current literature and perspective. While the program itself was evaluated and the findings indicated that it was successful in improving the participants health and wellbeing, the project process was recorded but not evaluated in any coherent form. I believe that
there is much merit in examining processes as well as outcomes in order to learn as much as we can about how to plan and implement successful health promotion programs. The Healthy and Wise Program outcomes are indicative of the value of using health promotion approaches to reduce the risk of depression and to build wellbeing in older people. I am confident that further development of the “art-science” of health promotion will offer increased benefits for positive aging.

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APPENDIX 2: HEALTHY AND WISE PROGRAM TOPICS

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APPENDIX 3: THE HEALTHY AND WISE PROJECT, SUMMARY OF EVALUATION FINDINGS

This summary was prepared by Robin Harvey as feedback for program participants and mentors and was approved by Suzy Gattuso, 1999. Evaluation examined pre and post program differences in wellbeing, and a six month follow up of participants was conducted. The program successfully attracted those potentially at risk for lowered wellbeing, with a significant proportion of participants reporting current chronic physical illness, previous mental health problems or low levels of social support. One third of participants rated themselves in the pre-program self-rating survey as experiencing a low sense of wellbeing. Wellbeing was measured by its inverse, using the Geriatric Depression Scale (GDS) which asks people to rate themselves against a number of indicators of depression in older people. The percentage of participants with moderate to high scores on the GDS pre-program exceeds the community prevalence statistics. There was a significant improvement in wellbeing across participants post program, as measured by the GDS and by participant self-report, with improvements maintained at six-month follow-up. Participants who were initially lower in wellbeing benefited most from the program and those who scored high on wellbeing from the start also reported finding the program of value. A very small number of participants were unable to benefit fully from the program because they faced very serious health or family problems, but gained from the support of the group. Although a majority of participants had experienced a challenging life event during the six-month follow-up period (eg. serious illness, loss) they were able to maintain wellbeing through changes in attitudes and behaviours which promoted and nurtured mental health. There was an overwhelming endorsement of the value of the program and the relevance of its content.

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The task as outlined below was agreed on via email with facilitator, 2/12/08.

“I was inspired by the Bathurst residential session on imbedding information and academic literacy skills into subjects, because this matched a need which I had just identified amongst some of my new grad cert students who entered that course with very little academic background, skills or confidence. What I propose to do, if it is acceptable, is to write a reflective piece about my learning from the process of identifying this issue, following up the imbedding examples from the presentation and other staff and then working in collaboration with a learning skills adviser and a library person to develop a totally revised DE subject with online skills modules which link with the gerontology content (in print form and online resources) and topics of what will now be an introductory subject for the course, GER401.” (Min. 700 words, excluding references).

Background

I attended TTC this year in my second year of fulltime employment as an academic and a course coordinator. My background is that of professional practice as a social worker working in the field of ageing, specifically aged psychiatry and mental health promotion with older people. In my professional practice I have developed some skills in using adult learning principles in my mental health promotion work with older people, specifically around facilitating participants to identify, utilise and develop their own skills, knowledge and experience in pursuit of their wellbeing goals (ie. starting where the participants are at) and supporting self-directed and collaborative learning. While I had experience as a sessional lecturer and tutor in social work on-campus teaching, in marking assignments for distance education subjects, and in a 12 month period of part-time subject coordination in the gerontology course prior to taking up this position in 2007, my starting knowledge of teaching by Distance Education, planning and developing teaching resource packages and course coordination issues could fairly be described as minimal to even less. My hopes in attending TTC were for inspiration and knowledge with which to develop my ability to shape both my teaching within subjects and the course and subject content and resources to better meet the needs of my students.

Identification of the “issue/problem”

My post-graduate gerontology courses are: Graduate Certificate in Gerontology and Master of Gerontology (coursework). Both are taught by Distance and they do not have associated residential programs. Students of both courses are predominantly mature aged and employed in aged services positions, with diverse backgrounds in nursing, allied health, or aged care management/administration. Students in the Graduate Certificate frequently have TAFE level qualifications only (eg. Certificate III or IV in aged care or...
community work) as a starting point and many students from both courses are returning to study after a significant period in the workforce and appear both unfamiliar with university level academic requirements and lacking in confidence in their academic skills.

During first semester 2007, my first year in this position, I became aware that many students, particularly in the Graduate Certificate, were initially struggling with the basic academic skills of library research, critical thinking and essay writing. Because the Grad. Cert. is a one year course, typically undertaken part-time, two subjects per semester, I realised that students lacking these basic academic skills on entry to this course were a quarter of the way through their course before I was able to identify, and provide specific feedback and advice to rectify, this problem via assessment of their first assignments, due midway through their first semester.

I also observed that the process of struggling with their first assignments, receiving low grades for their work and needing to address significant identified areas for improvement in these basic academic skills areas, appeared, unsurprisingly, to exacerbate lack of confidence for these students. This was so despite my attempts to provide constructive areas for development within careful and very encouraging feedback. This was far less than an optimal start to their study and learning experience at CSU.

**Initial attempts to address the problem**

For students in the mid-year intake in 2007, I attempted to avert this situation by informing students about CSU’s Study Link online study preparation courses and advising them to consider whether the Academic Skills Development subject would be useful for them to undertake and complete prior to beginning their course.

I also posted messages to the subject forums early in the semester encouraging students to use the services of the Learning Skills Advisers if needed to support their study and encouraged them to ask questions of me. I found that the online forums were very quiet with few students posting questions or responding to my postings.

I attempted to investigate my students use of the online forums by joining the Interact Site Tools Pilot in 2008 to investigate actual use of interact tools within the subjects GER401 and GER402. My speculation, based on student demographics, was that that my students may not be using the online forums due to either a) lack of skill/ confidence online or b) difficulties with access to internet.

The Pilot study showed me that students were, in fact, accessing the forum frequently but rarely making postings. This was very useful information, indicating that my fears about using online methods to support learning for this
group appeared largely unfounded and that confidence in posting online may be the likely barrier rather than lack of computer skills or IT access.

Whilst I obtained no evidence to indicate whether students were taking up the Study Link or Learning Skills Advisors options, the issue as described above was repeated amongst new students in the mid-year 2007 and Feb. 2008 intakes of students so I can conclude that my initial efforts to address the issue were unsuccessful.

**Solution Stimulus/TTC**

I attended the first session of TTC in April 2008, hoping for some inspiration as to how to respond to this issue. My notes following the first session included the following: “Develop library and online lit./ data base search skills hurdle for new students to course (GER402/401).” Thus my thoughts were already turning to the possibility of identifying one of the core subjects in the Graduate Certificate as a library skills building vehicle in some way. However, it wasn’t until the TTC residential sessions at Bathurst that the potential for building not only library but also academic skills into a subject was revealed to me in the presentation entitled “*Embedding Academic and Information Literacy into your Teaching*”. I found the ideas in this presentation really exciting as they appeared to offer a process and potential solutions to a similar issue to mine.

**Steps to implementing my own solution**

Following the session I communicated further with presenters and was given access to the SAILS (Study and Information Literacy Skills) Interact site where I considered the various online modules which other academics had developed. Reviewing these modules was very helpful in showing me some examples of what could be done and the information which others had developed, however, I didn’t find modules which I felt precisely met my students particular needs, as I perceived them, or matched my developing hopes and expectations for a Distance Education skills building subject which could provide a transition into post-graduate tertiary study for my students.

I applied for and received a Faculty Subject Development award for 2008/9 in order to further develop my own SAILS solution within the subject GER401 Choices and Options in later Life. This subject is a core subject for the Graduate Certificate, is also used as a subject within the Masters program and has potential to be scheduled as a first session subject for all students entering either of these courses. This makes it a useful vehicle in which to imbed the academic and information literacy skills which I had identified many students as lacking on entry in to the courses. The faculty award was extremely helpful in enabling me to buy out marking load during 200870 in order to have time to work on what had become a complete rewriting of the GER401 print study package as well as development of the online SAILS modules.
Following the collaborative model outlined in the TTC session, I contacted the Library and Student Services from Thurgoona campus and began working with colleagues from these services to develop relevant online modules to support students entering my courses.

The print package was revised and updated following plans I already had to develop the content, however, I found that the collaboration with Library and Learning Skills staff gave me a much broader and deeper appreciation of ways in which the subject content could support and interact with the skills development modules in positive ways to support and extend student learning, hence the complete rewrite which occurred.

The GER401 solution/outcome

GER401 will be offered in 200940 for the first time as an introductory subject for the gerontology courses with the following integrated resources: Print study package comprising Subject Outline, Study Guide, and Readings package: Online material including 4 SAILS modules together with online readings and supplementary resource materials.

The print and online resources are carefully integrated and guide students through initial print based introductions to subject content, followed by step by step introduction to the Interact environment and skills modules which utilise subject content within the skills tasks, and returning to the print study guide to further develop subject content backed up by a mix of print and online readings and resources.

Clear instructions for “navigating” this mixed print and online subject have been developed and repeated in both the Subject Outline and the Study Guide (at Educational Designers suggestion) in order to maximise clarity for students, no matter where they start reading their subject package.

Subject content is as follows (with print resources identified in ordinary type and online resources in Italics), “topics” identify gerontology content and “modules” reflect skills development content. The online skills development content includes links to relevant CSU online study support features, such as Library Smart Skills tutorials, referencing and plagiarism quizzes, and contains assessable skills tasks which are linked to, and building research towards, the final assignment (essay topic):

Introduction to Subject and “navigation” guide

Introduction to theory in gerontology and in context of this subject

Topic 1: Social Determinants of Health in Later Life (overarching topic within which following specific topics fit, as examples)

Topic 2: Lifelong Learning introduction
Module 1 Yourself as a Lifelong Learner – preparing for study, Distance Education, using Interact tools, forums for exchange of ideas, planning for learning (time management, goal setting, learning styles), active learning, reading and notetaking skills (LSA)

Module 2 Library skills – finding and evaluating information (Library)

Module 3 Library skills – using data-bases and evaluating your search results (Library)

Module 4 Academic skills development – writing in the post-graduate academic context (essay writing skills, referencing, plagiarism, critical analysis and reflective learning) (LSA)

Lifelong Learning and Older Adults
Topic 3 Nutrition, Exercise and Active Aging
Topic 4 Work, Retirement and Income in Later Life
Topic 5 Housing, Transport and Environmental Issues in Later Life

Assessment for the subject now consists of two assignments

Assignment 1 is a Portfolio of responses to the skills tasks which are imbedded within the online modules and a reflection on individual lifelong learning goals and application of this study to student’s own professional development, worth 40% of subject marks.

Assignment 2 is an essay on subject gerontology content, including critical analysis and reflective skills, worth 60% of subject marks.

Reflection on my learning from this process

One of the neatest (entirely coincidental and serendipitous) aspects of this whole process is that the subject chosen as the vehicle for this development already contained a topic on Lifelong Learning (in the context of older adults and ageing) which makes a perfect vehicle for imbedding SAILS content in the context of students reflecting on their own lifelong learning needs as new DE students entering the postgraduate gerontology courses. (It also links nicely with my need to reflect on my learning process for the purposes of my TTC task and, of course, for my ongoing teaching development.) However, the potential for building on this coherence wasn’t immediately apparent to me until pointed out by LSA colleague. From this synchronicity, we were able to build what I hope will be a really well integrated and much deeper and more reflective learning skills development experience for students. This created significantly greater scaffolding of learning than my initial limited plans for some library and critical thinking skills. I hope that GER401 will provide a
really strong introduction to post-graduate study which will position students well to gain maximum benefit from all their other subjects and do well in their courses.

One of the key things I have learned (or rather, which has been reinforced) from this experience is the value, even critical importance, of working in collaboration with others. This experience has made me much more aware of the need to actively construct collaborative relationships with others to compensate for the lack of a large discipline team. I have greatly benefited from the perspectives and knowledge of the two members of our collaborative team for GER401 and we have all enjoyed and learned from each other within the process of development of the subject. I hope to maintain collaborative relationships with each of them as one way to maintain my learning as a teacher and continue development of fresh approaches to subject and skills design.

The SAILS interact site has also allowed me to share an online collaboration with others ideas and was a wonderful resource and I have enjoyed learning about how to use the online Interact environment better which will be of value in all my future teaching.

As with my hopes for the students of this subject, I have also been able to generalise my learning, in this case by building components of further skills development into another subject later in the courses, GER501, which encourages the development of a higher level of critical analysis and reflection through critiques of different sources of material and context of views (e.g. political policy documents, press releases, peer-reviewed journals, newspaper articles) embedded in the subject content together with further translation of theory in to practice through reflective tasks which students should now be well fitted to undertake.

My understanding of the processes of teaching and learning have also extended to engage with the opportunities to learn skills (learning how to learn and think) at the same time as learning content about ageing. This has built on my existing frameworks of adult learning as needing to start from where the students experience is and move forward from there.

The whole process has been so challenging and stimulating that I have thoroughly enjoyed it.

I look forward to teaching this subject in 200940, evaluating with students how well it is meeting their needs and continuing to develop GER401.