Edukacja 2025, 4(175)
DOI 10.24131/3724.250401
e-ISSN 2449-8998

Health Pedagogy: Historical Overview, Development Prospects and a Proposed Pedagogical Model of Resilience and Health

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Abstract

Health pedagogy in Poland developed in close connection with social, cultural, and systemic changes, treating health not only as a biological value, but also as a psychological, educational, axiological, and social category. Today, it is an interdisciplinary subdiscipline that studies the psychological and socio-environmental determinants of health and disease and identifies educational and preventive measures for various social groups, taking into account physical, mental, emotional, social, and spiritual well-being. This article presents a brief historical overview of health education in Poland – from early activities in the field of hygiene education and disease prevention to contemporary concepts of multidimensional health education. Next, the inclusion of the psychological determinants of health is proposed, with particular emphasis on resilience, and supports the development of upbringing and educational methods. Finally, a conceptual model of resilience and health is presented, integrating various dimensions of an individual's functioning in a psychosocial context.

Keywords: **Health pedagogy, health, resilience, social prevention.**

Pedagogika zdrowia: Rys historyczny, perspektywy rozwoju i propozycja pedagogicznego modelu resilience i zdrowia

Streszczenie

Pedagogika zdrowia w Polsce wykształcała się w ścisłym związku z przemianami społecznymi, kulturowymi i systemowymi, traktując zdrowie nie tylko jako wartość biologiczną, lecz także jako kategorię psychologiczną, wychowawczą, aksjologiczną i społeczną. Współcześnie jest to subdyscyplina interdyscyplinarna, badająca psychologiczne i społeczno-środowiskowe uwarunkowania zdrowia i choroby oraz wskazująca na działania edukacyjne i profilaktyczne na rzecz różnych grup społecznych. Uwzględnia zarówno dobrostan fizyczny, jak i psychiczny, emocjonalny, społeczny i duchowy. Artykuł przedstawia krótki rys historyczny pedagogiki zdrowia w Polsce – od wczesnych działań w zakresie edukacji higienicznej i profilaktyki chorób po współczesne koncepcje wielowymiarowej edukacji zdrowotnej. W dalszej części proponowane jest włączenie psychologicznych uwarunkowań zdrowia ze szczególnym uwzględnieniem resilience, co wspiera rozwój metod wychowawczych i edukacyjnych. Na zakończenie zaprezentowano koncepcyjny model resilience i zdrowia, integrujący różne wymiary funkcjonowania jednostki w kontekście psychospołecznym.

Słowa kluczowe: **Pedagogika zdrowia, zdrowie, resilience, profilaktyka społeczna.**

1. INTRODUCTION

Health pedagogy, as a subdiscipline of pedagogy, has developed in Poland over the last few decades in close connection with social, cultural, and systemic changes. Its basic assumptions are based on treating health not only as a biological value, but also as a psychological and medical category, as well as in educational, axiological, and social aspects. From a humanistic perspective, health is not only a condition for the quality of life, but also the result of the process of education and the development of individual responsibility (Syrek, 1997, 2019b).

Currently, health pedagogy in Poland is understood as an interdisciplinary field of research and practice focusing on the socio-environmental determinants of health and disease, multifaceted and multisectoral institutional and non-institutional activities for various social groups, as well as the evaluation of health education processes (Syrek, 2008, 2019a). From a pedagogical perspective, health is not limited to the physical aspect, but also includes mental, emotional, and social well-being, as well as, increasingly, spiritual well-being (Skalski-Bednarz et al., 2024; Surzykiewicz et al., 2022), which is reflected in multidimensional models of health education (Heszen-Niejodek & Sęk, 2012).

The aim of this article is to present a historical overview of the development of health pedagogy in Poland, covering both the first attempts to understand hygiene education and disease prevention, as well as the development of contemporary thinking and concepts. In the further part of the article, I propose enriching the subdiscipline of health pedagogy with the psychological determinants of health, with particular emphasis on resilience, which enables the development of educational and upbringing methodologies supporting the comprehensive development of the individual in a psychosocial context. Finally, I present a conceptual, theoretical model of resilience and health that integrates various dimensions of human functioning.

2. A BRIEF HISTORY OF THE DEVELOPMENT OF HEALTH PEDAGOGY IN POLAND

The development of health pedagogy in Poland has been and continues to be a response to the changing health challenges of individuals and society, growing awareness of the psychosocial determinants of health, and the need to integrate medical, psychological, and pedagogical knowledge (Syrek, 2019b; Woynarowska, 2008). In health education, particular emphasis is currently placed on supporting individual agency, shaping life skills conducive to a healthy lifestyle, and developing ethical, moral, and reflective attitudes in the context of health and mental and social well-being (Demel, 2002; Konaszewski, 2020; Syrek, 1997).

In the Polish tradition, theoretical reflection on health was developed by, among others, Grzegorz Piramowicz (who set teachers the task of "health education") and Jędrzej Śniadecki, author of the treatise "On the Physical Education of Children" (Piramowicz, 1872; Śniadecki, 1867). In "The Sociology of Education," Florian Znaniecki drew attention to the individual's contribution to the biological basis of a social group, pointing out that physical types differ depending on the social functions that a person's body is to serve (Znaniecki, 1973). The beginnings of systematic health education in schools in Poland can be dated to the second half of the 19th century, when gymnastics classes (the precursor to physical education) were introduced. In the first half of the 20th century, education focused mainly on hygiene and disease prevention (which recognized the health risks associated with school and focused primarily on the prevention of infectious diseases) (Woynarowska 2000), then evolved towards health education, taking into account its socio-cultural determinants. An important role here was played by the school of Helena Radlińska, a pioneer of social pedagogy, whose interest in medical care and experience in medical and nursing work influenced the development of empirical pedagogy and social work theory (Radlińska, 1935; Radlińska et al., 1961).

A significant milestone was the publication of Maciej Demel's first monograph, "On Health Education", published by Państwowe Zakłady Wydawnictw Szkolnych (Demel, 1965). From that moment on, pedagogy began to play the role of a co-creator of health, rather than, as before, merely a passive recipient (Demel, 1965; Syrek, 1997). Importantly, Demel distinguished health pedagogy as an independent subdiscipline of pedagogy, formulating its subject matter, goals, and tasks, and pointing to its interdisciplinary nature and links with prevention and health promotion (Demel, 2002).

It should be noted that the term "therapeutic pedagogy" was used in the first half of the 20th century as a substitute for the term "special pedagogy" as can be seen in Maria Grzegorzewska's textbook "Special Pedagogy. Lecture Notes" (Syrek, 1997, 2000). Edward A. Mazurkiewicz pointed out that the term "health pedagogy" was shaped by retrospective works synthesizing scientific achievements from the borderline between social medicine and social pedagogy (Mazurkiewicz, 2001).

An increase in interest in pedagogy and health issues has been observed particularly since the 1990s, when Poland was included in the World Health Organization pilot project Health Promoting School (1991/1992). Since then, there has been a wealth of health promotion concepts developed in Western countries and an intensive development of health-related research and pedagogical practices. Health promotion is understood in this respect as a process of enabling people to increase their control over the factors determining their health in order to improve it (Woynarowska, 2008, 2012; Woynarowska & Woynarowska-Sołdan, 2015)

In this context, it is also worth emphasizing the importance of the work of Czesław Kupisiewicz (who drew attention to the role of health education in preparing the younger generation to take responsibility for their own health), Barbara Woynarowska

(who emphasized the promotion of health and well-being as an integral task of pedagogy), and Ewa Syrek (who developed the interdisciplinary foundations of health pedagogy and showed its links with social pedagogy). Syrek (2008) emphasized that health pedagogy adapts the concepts and achievements of pedagogy and other sciences in order to design health-promoting activities in the various environments of people of different ages. At the same time, she pointed out that looking at the context of "health in pedagogy" means using contemporary concepts of health, illness, and health promotion also in areas such as social rehabilitation pedagogy, didactics, and preventive intervention.

Currently, health and well-being are defined as multidimensional concepts encompassing physical, mental, social, cultural, and spiritual spheres (Heszen & Sęk, 2007). The World Health Organization (1946) defines health as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity" (Langford et al., 2014). In health education, particular emphasis is placed on a holistic approach that integrates prevention, health promotion, and psychosocial support. Based on this perspective, we can distinguish two paradigms of considering health, which offer, on the one hand, opposing views, but on the other, are currently complementary. We can now use them to examine the human experience of health and disease: pathogenesis and salutogenesis. Pathogenesis is the traditional approach, focusing on the causes and mechanisms of disease. Salutogenesis, introduced by Antonovsky, shifts our attention from disease and risk factors to understanding the sources of health and what promotes it (A. Antonovsky, 1995).

3. HEALTH PEDAGOGY: THE PERSPECTIVE OF DEVELOPMENT IN THE AREA OF RESILIENCE

As already indicated, health pedagogy, understood as a subdiscipline of pedagogy, currently focuses on the study of the socio-environmental determinants of health and disease, multifaceted institutional and non-institutional activities for the health of various social groups, as well as the analysis and evaluation of the health education process aimed at improving physical, mental, and social health. Today, this approach can be supplemented by the perspective of the psychological concept of resilience, which contributes several key elements:

1. Multifactorial approach – health pedagogy gains an additional dimension by taking into account both personal resources (e.g., coherence, self-efficacy, forgiveness) and environmental resources (support from family, school, social institutions). The interaction of these areas promotes a more comprehensive design of educational activities (H. Antonovsky & Sagy, 1986; Bandura, 1997; Konaszewski, Niesiobędzka, et al., 2019).

2. Resilience as a predictor of health – resilience plays a role as a factor determining the long-term development of an individual. Research indicates that a high level of psychological resilience promotes the maintenance of pro-health behaviors, increases the effectiveness of stress coping strategies, and provides an important buffer against the negative effects of risk factors. This means that resilience can be treated as a predictor of health, quality of life, and well-being (Konaszewski, Kolemba, et al., 2019; Skalski et al., 2022).

3. Resilience as a mediator – in addition to its predictive function, resilience in the health education process acts as an intermediary between adverse experiences (illness, social crisis, poverty) and an individual's emotional and behavioral responses. When properly supported, mental resilience can minimize the negative effects of crises and strengthen recovery and adaptation processes (Konaszewski et al., 2023).

4. Resilience as a health outcome – resilience can also function as a result of educational and upbringing influences. In this sense, pedagogical, preventive, and educational activities are aimed not only at imparting knowledge or supporting current needs, but also at shaping mental resilience as an effect of the upbringing process. For example, educational resilience can be understood as the ability of students to adapt, self-regulate, and constructively cope with difficulties in the school context, which is the result of thoughtful educational interventions. This approach allows resilience to be treated both as a goal and as a measurable result of pedagogical activities (Windle et al., 2011).

5. Positive diagnosis based on resilience – health pedagogy supplemented with resilience emphasizes not only the identification of deficits, but also the recognition of the resources of the individual and their environment. The diagnosis then becomes two-pronged and dynamic, and the planned educational and compensatory measures can be more precise and adequate to real needs (Wysocka, 2015, 2017).

6. Life cycle and hardening effect – resilience allows us to analyze health and illness from a whole-life perspective, taking into account turning points and the individual's ability to "bounce back" from previous difficulties. Health education can thus more effectively support adaptive processes at different stages of development (Davey et al., 2003; Egeland et al., 1993).

7. Resilience as a health metacompetence – in educational practice, resilience can be understood as the ability to learn coping strategies, regulate emotions, and creatively interpret health crises. This means that health education is not limited to the transfer of knowledge, but develops the individual's ability to consciously manage their own life in a health-promoting way (Alvord et al., 2014; Wellensiek, 2011).

In this way, health pedagogy becomes not only a science of health promotion, but also, to some extent, an empirically verified discipline and educational practice that combines diagnosis, prevention, support, and strengthening of individual and environmental resources. Its role is to prepare people to deal constructively with the uncertainty and fragility of life, while developing pro-social skills, reflectiveness, and the ability to make their own decisions.

In this context, diagnostic expertise, understood as the process of recognizing the properties, origins, functions, stage, and predicted development of a given state of affairs or problem, takes on particular importance (Kawula, 1978; Wysocka, 2017; Ziemski, 1973). It makes it possible to answer the question of what the existing state is and how it differs from the postulated one, and this difference determines the goal of potential action. Diagnosis, supported by axiological expertise, allows us to determine whether intervention is necessary at all, and if so, what its strategy should be (Konaszewski, 2014). In the social sciences, diagnosis cannot be limited to the descriptive dimension alone. Treated as a process, it encompasses successive stages – from describing the educational situation and personality traits of the individual, through identifying the psychosocial mechanisms of disorders, to predicting their consequences and designing corrective measures. The following are distinguished here, among others:

1. Positive diagnosis, focusing on the strengths of the individual and their environment, identifying talents, potential, and interests. This stage helps to understand, build, and develop the resources already existing in the individual.
2. Negative diagnosis, focusing on deficits, disorders, and mechanisms of dysfunction. It allows for the identification of areas requiring support or intervention.
3. Genetic diagnosis, explaining the causes of phenomena. This stage allows for understanding where specific problems or behaviors come from.
4. Meaning diagnosis, determining their role in a broader context. It facilitates the assessment of the impact of a given phenomenon on the development of the individual and their environment.
5. Phase diagnosis, indicating the stage of development of the phenomenon under study. This enables actions to be adapted to the current level of development or difficulty.
6. Prognostic diagnosis, allowing the direction of further changes to be predicted and appropriate educational or preventive measures to be identified (Ziemski, 1973). On this basis, a design diagnosis is also formulated, which indicates potential methodological solutions and strategies for educational, preventive, or rehabilitation measures. The final stage is the verification diagnosis, whose task is to verify the effectiveness of the implemented measures and the accuracy of the adopted assumptions (Konaszewski, 2014; Wysocka, 2017).

The inclusion of this perspective in health pedagogy emphasizes that its task is not only to describe health problems or promote prevention, but also to develop comprehensive models of diagnosis and action that allow for real support for the development of the individual and the optimization of social living conditions.

4. PROPOSAL FOR A CONCEPTUAL PEDAGOGICAL MODEL OF RESILIENCE AND HEALTH

The phenomenon of resilience is described through the ability to bounce back after difficulties, return to health, protective factors, individual characteristics, and positive functioning outcomes (Fergus & Zimmerman, 2005; Seery et al., 2010; Zolli & Healy, 2012). In psychological terms, resilience refers to the characteristics of an individual that enable adaptation to stress and adversity (Wagnild, 2013). It is also understood as a process of coping with predictable negative effects (Luthar et al., 2000; Rutter, 2012). Its application in traumatic and stressful contexts highlights the importance of this construct for the individual, as well as in broader socio-ecological contexts and at the community level, in response to traumatic or catastrophic events and tragedies (Adger, 2000; Ungar, 2011). However, existing models do not fully capture the multidimensional nature of resilience and its relationship to health (Liu et al., 2017). In response to these limitations, I propose the Pedagogical Model of Resilience and Health (PMR&H), which takes into account different levels and dimensions of individual functioning. The proposed model develops and deepens the concept of resilience-sensitive pedagogy, presenting it in a broader theoretical, empirical, and practical perspective (Konaszewski, 2020). To capture the interactive and dynamic nature of resilience, this model adopts a multidimensional and multisystemic approach. PMR&H distinguishes three layers:

1. Individual resilience – encompasses an individual's internal characteristics, such as physiology, biological responses, health behaviors, and other biological indicators that form the basis of an individual's resilience throughout their life. Biological and genetic determinants influence the ability to adapt to stress and counteract risk (Charney, 2004; Masten & Obradović, 2006).
2. Internal resilience – reflects interpersonal and psychosocial characteristics that can be developed throughout life through experiences and social interactions. This layer includes, among others: a sense of coherence, resilience, coping styles, self-efficacy, and social competence (Konaszewski, 2020; Konaszewski et al., 2022; Wagnild & Young, 1993).

3. External resilience – includes the socio-ecological and cultural context, including formal and informal institutions, socioeconomic status, access to services, family, school, and local environment, as well as cultural and spiritual factors (Adger, 2000; Folke et al., 2010).

The integration of these three levels allows us to grasp the complexity of resilience as a protective health mechanism that enables individuals to thrive in the face of adversity and can be an important goal of education, prevention, and health promotion. PMR&H allows us to study both individual and environmental resilience, without limiting it solely to the context of risk. The inclusion of biological and physiological indicators—such as brain function, the neuroendocrine and immune systems, gene expression, and health behaviors—provides a better understanding of the basis of individual resilience (Curtis & Cicchetti, 2003). PMR&H also takes into account the influence of stable factors such as gender, age, and ethnicity, which form the foundation for dynamic interaction with the internal and external layers (Liu et al., 2017). The PMR&H model offers two research perspectives:

1. Micro perspective – allows for detailed analysis of mechanisms within individual and internal resilience, e.g., the relationship between personality traits, coping skills, and health outcomes.
2. Macro perspective – enables the study of socio-cultural determinants of external resilience, such as the influence of family, school, peers, and the local community on the development of protective resources and individual health.

In the model (PMR&H), resilience is treated as an interactive and dynamic process, encompassing individual, interpersonal, and socio-ecological factors. The model takes into account both the traditional psychological approach and new biological and physiological indicators, creating a comprehensive framework for researching and supporting individual health. The model also emphasizes the importance of pedagogical and psychological activities that allow for the practical strengthening of individuals' resilience in various life contexts. As a result, the model is a holistic tool for analyzing human functioning and diagnosing resilience in individual, interpersonal, and socio-ecological dimensions, creating a basis for designing effective prevention and health promotion strategies.

In summary, the nature of the resilience process is understood as an interaction between individuals (their characteristics, properties, and resources) and their broader socio-ecological context. I therefore propose a multi-level pedagogical model of resilience that includes individual (biological-physiological), interpersonal (internal-personality), socio-ecological, and socio-cultural (external) variables and emphasizes the interactive process of resilience, which is dynamic and multidimensional. The model allows for an understanding of resilience processes with an emphasis on recognizing individual resilience and internal resilience, referring to the diagnosis of personality and social resources and the search for broader correlates relating to external resilience. In addition, in the model, I draw attention to the methodological aspect, in which I emphasize the need for pedagogical and psychological interventions that are so important in today's changing world. PMR&H is, in a sense, a holistic approach to developing an optimal empirical analysis of an individual's functioning, allowing resilience to be recognized and explained from different perspectives and in different dimensions. The inclusion of this model in the field of health pedagogy is a proposal to enrich it with a psychological, social, and biological dimension, which broadens the current approaches to health, directing them towards shaping the individual's resilience to the challenges of the modern world. With its inclusion, health education can more fully fulfill its tasks, combining prevention and education with the development of resilience competencies that promote long-term well-being and the quality of life.

5. SUMMARY AND CONCLUSIONS

Health education in Poland grew out of the tradition of social pedagogy and health education (e.g., Śniadecki, Radlińska), and in recent decades, it has been established as an independent subdiscipline of pedagogy thanks to the work of Demel, Wysocka, Syrek, and Woynarowska. Today, its task is not only health education in schools, but also supporting the quality of life, developing resilience, and shaping responsibility for health on an individual and social scale. My proposal for health pedagogy, combining theoretical foundations and empirical research, as well as taking into account personality and context analyses, enriches this subdiscipline with new perspectives. The introduction of the conceptual Pedagogical Model of Resilience and Health (PMR&H) allows us to look at health and education in a more holistic way, covering the biological-physiological, psychological, interpersonal, and socio-ecological levels. This model emphasizes the interactive and dynamic nature of health-promoting processes, presenting resilience as a predictor, mediator, and health outcome, as well as a competence that can be developed through educational and upbringing activities. As a result, health education gains a broader, holistic dimension that goes beyond the traditional approach to prevention and health promotion. Taking resilience into account as a key category allows for the design of educational and preventive measures that are not limited to avoiding risks, but actively strengthen the resources of individuals and groups, preparing them to cope with uncertainty and crises.

The significance of such enriched health education lies in providing a framework for education and pedagogical practice that enables people to better understand themselves and the world and to take responsible action for their health and quality of life.

Taking PMR&H into account paves the way for modern strategies for shaping well-being, building mental resilience, and developing the competencies necessary to function in today's dynamically changing world.

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