Understanding Community Wellness from a Multicultural Perspective

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Abstract

This research was part of the first phase of a broader action research project known as the Community Wellness Project. The project was initiated by Isaac Prilleltensky and Heather Gridley from Victoria University and involved a partnership between Victoria University and Good Shepherd Youth and Family Service, St Albans (Melbourne, Australia). The present study aimed to explore Prilleltensky's community wellness model and cycle of praxis in qualitative research with diverse community members from the St Albans region of Melbourne. The emphasis of the study was on the ideals, needs and strengths of the community and on possible actions to improve well-being. Four focus groups with Maltese, Vietnamese, Anglo and Italian community members, and two individual interviews with Maltese and Serbian women were conducted (a total of 31 people). The analysis of findings revealed 15 community ideals or common themes, with three classified as personal, five as relational and seven as collective. The research also pointed to areas of need and strength and recommendations for action to improve well-being in the community.

Acknowledgements

I would like to thank Professor Isaac Prilleltensky and Ms Heather Gridley (Victoria University) for initiating the Community Wellness Project and giving me the opportunity to be a part of it. As a supervisor, Isaac was patient, thoughtful and astute and his reflections and comments were very helpful. Isaac lives and works in close concordance with the values he espouses, so as a student I felt competent, optimistic and respected as well as proud of the broader work he was doing. Acknowledgements are about goodbyes as well as thankyous, so I would like to convey a special goodbye and thankyou to all the lecturers who were part of the community psychology course over the past few years. A special acknowledgement must go to Heather for her years of hard work in establishing the course and for the time and wealth of information she freely gives to students. My family, friends, relatives and husband in particular deserve a special mention for their support and patience over the years. I would also like to thank Donna Robertson for her insights and support during the research phase and for the ongoing friendship developed out of this time. Acknowledgements must also go to the Australian Research Council for funding the first phase as well as the VU and Good Shepherd Youth and Family Service project steering committee members and GSYFS staff for their collaboration and interest. Last and especially, I would like to extend a warm thankyou to the participants involved in the research. Hearing what community members had to say made it all worthwhile.

Declaration

"I declare that this report does not incorporate any materials previously written by another person except where due reference is made in the text".

"I further declare that this study had adhered to the ethical principles as established by the Psychology Ethics Committee of the Victoria University".

Signature:

Name: Victoria (Vicky) Totikidis

Date: 21-10-2002

(From Appendix D, Department of Psychology Honours Manual, Victoria University)

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CHAPTER ONE

Introduction

Community Wellness

Wellness promotion strategies should be guided by a broad definition of wellness and by community members' opinions on what wellness means and what they need to achieve it. Individuals, communities and cultural groups may ascribe different meanings to concepts such as health, wellness, or well-being. Therefore, consultation with these stakeholders is vital. Definitions are important because they ultimately determine what actions health and community workers, researchers, policy makers and governments take to promote wellness. A narrow definition of wellness typically justifies a limited scope that takes into account only the physical or psychological aspects of health and well-being. In contrast, holistic, psycho-social, ecological or community approaches also consider the broader social, cultural, political and environmental factors that impinge on individual and community wellness.

Community development workers, social workers, and applied community psychologists require holistic models of wellness to inform and guide their work. Individualistic models may be suited to medical settings but can be 'victim blaming' (Ryan, 1971). Narrow models of wellness can also justify an ameliorative approach. However, broader transformations of pernicious social systems are required to promote human liberation (Prilleltensky & Nelson, 2002).

In the present context, the terms wellness and well-being are used more or less interchangeably to refer to a holistic state of health. This is consistent with the definition outlined in the constitution of the World Health Organization (WHO). According to the WHO: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (1946; in Commonwealth of Australia, 1997, p.1).

The use of the terms wellness and well-being in the present context are especially associated with Prilleltensky's (2001a) Community Wellness Model (see literature

review for earlier versions of the model and contributing authors). The Community Wellness Model is an ecological model of well-being that encompasses the WHO definition. A major assumption associated with the model is that "wellness is a positive state of affairs brought about by the simultaneous satisfaction of personal, relational, and collective needs of individuals and communities" (2001a, p.2). According to the model, personal wellness needs include biological and psychological factors such as the need for a sense of control over one's life, physical health, love, competence, optimism and self-esteem. Relational wellness needs include the need for social support, affection, belonging, cohesion, collaboration, respect for one's diversity and democratic participation in decisions and actions that affect one's life. Collective wellness needs include the need for economic security, social justice, adequate health and social services, low crime (safety), adequate housing and social structures (e.g., educational, recreational, transportation and shopping facilities) and a clean environment (Prilleltensky, 2001a).

The Community Wellness Project

In 2001, Isaac Prilleltensky and Heather Gridley from Victoria University (VU) initiated a participatory action research project known as the Community Wellness Project. The two complementary aims of their project were: a) to refine the Community Wellness Model by grounding it in an applied setting, and b) to facilitate community improvement in the multicultural western region of St Albans (Melbourne, Australia) (Prilleltensky & Gridley, 2001). The project consists of a research and community development partnership between Victoria University, Wellness Promotion Unit and a local community service agency known as Good Shepherd Youth and Family Service (GSYFS). Both institutions are situated in St Albans and have a common concern about disadvantage and social justice within this region.

Prilleltensky and Gridley (2001) have referred to the framework as a model for community assessment and change, while acknowledging that the model must be grounded in the lived experience of community members. This is consistent with an action research paradigm, which considers the role of the researched as vitally important to both the discovery of meaning and to future action arising from the research. According to Curtis, Bryce and Treloar:

> The role of the researcher in action research is to participate meaningfully and productively in the knowledge-generating processes of the group. The development of options for change and definitions of effective change are products of collaborative action, reflection and negotiation. In action researching approaches, the participants are themselves taken to be the experts in their own lived experiences (1999, pp. 202-203).

Grounding the model involves the recognition that while some of the needs represented in the model may be universal, the type and degree of need at each of these levels will differ from individual to individual and community to community - depending on existing strengths, resources and personal and cultural values. Moreover, some individuals or communities may have specific needs that have not even been considered in the model. Needs and values must be explored anew in each community as implied in the following quote: "the particular configuration of values required for human welfare changes from society to society, group to group, and time to time" (Prilleltensky & Fox, 1997, p.9).

The Community Wellness Project is composed of various parts and phases over a three-year period. Phase-one included the present research with diverse community members (Vicky Totikidis) and another project of similar scope with community service workers (Donna Robertson). Phase-two (currently underway) involves social action strategies with young people in the community (Julie Morsillo). Phase-one was funded by an Australian Research Council (ARC) Small Grants Award and phase-two by an ARC Linkage Grant. A map of the broader project may be seen in Appendix A.

The Community of Interest

In the present context, the term community refers to St Albans and more broadly to the Brimbank region and its people. St Albans is a suburb in the local government area of Brimbank and is one of the most culturally and linguistically diverse communities in the state of Victoria. It should be acknowledged that the Marin - Bulluk Clan of the Wurundjeri Tribe are the traditional owners of the land now known as St Albans (Westvale Community Centre, 2001) but at present less than 500 indigenous people (both Aboriginal and Torres Strait Islanders) reside in Brimbank (Australian Bureau of Statistics (ABS), 2002).

Australian born people make up the largest group in the Brimbank region (82,831 people or 50.84% of the Brimbank population), although figures regarding how many are Anglo-Australian (those born in Australia and associated with an English speaking background) and how many are children of non-English speaking background migrants are inconclusive. Most statistics are concerned with birth status and thus conceal the 'cultural identity' or ethnicity of the next generation. Even so, it is known that more than 46% (75,414) of the Brimbank population were born in a non-English speaking (NES) country and that about 57% (87,828) speak a language other than English at home (ABS, 2002). People born in *Vietnam, Malta and Italy* constitute the largest NESB cultural groups in the Brimbank region, with figures of 13,466; 7,056 and 4,423; respectively (ABS, 2002). St Albans is rich and unique in terms of its cultural diversity but is also generally known to be a disadvantaged region. This is a complex situation that requires an ecological understanding and analysis as implied in the Community Wellness Model.

The Present Study

The present research forms the thesis component of a Masters of Applied (Community) Psychology at Victoria University. The overarching aim of the study was to explore the Community Wellness Model in research with diverse community members from the St Albans region. The potential benefits of this study include an improved understanding of wellness from a multicultural perspective, while on the practical level it could guide actions to improve wellness in the community.

This research was an exploratory qualitative study that involved four focus groups with the major cultural groups who reside in the region (Anglo, Italian, Maltese and Vietnamese Australians) and two individual interviews with a Maltese and a Serbian woman (to pilot and further test the framework). Specific research questions appear just prior to the methodology section following a review of literature related to wellness in chapter two and the theoretical framework in chapter three. The methodology appears in chapter four and is followed by the findings and discussion in chapter five and conclusions in chapter six.

CHAPTER TWO

Review of Wellness

Our use of the term ‘wellness’ is closely connected to the discipline of community psychology; however, community health and well-being are interdisciplinary concerns. Community wellness is informed by literature dealing with community development, community building, social indicators, social capital, the ‘good community’, life satisfaction, subjective well-being and quality of life research. Due to the limitations of a thesis of this scope, only a very small portion of the relevant literature can be discussed. This chapter consists of a brief review of the community psychology roots of the present project; an outline of several other holistic models that could be used to promote well-being; and a section on wellness in a multicultural context.

Community Psychology Roots

The Community Wellness Model is essentially a Community Psychology endeavour. Community psychology emerged in North America during the socio-political activities of the 1960’s and out of a concern with mental health problems in society (Rappaport, 1977). Rappaport implies that community psychology was dissatisfied with totally intrapsychic explanations of mental health and adopted an ideology of prevention, believing that there was a “need to prevent problems in living by changing the social conditions that create them” (p.16).

Community psychology consists of a set of principles, values and concepts that guide community psychologists in their work. These include an ecological perspective, respect for diversity, collaboration with other disciplines (Duffy & Wong, 1996), the concept of psychological sense of community (Sarason, 1974), empowerment, prevention, micro to macro levels of analysis, social support and a “proactive, seeking out approach to assessing needs and special risks in a community” (Orford, 1993, p.4). The field also accepts a broader range of research methods than just the traditional quantitative methods, including qualitative interviewing, focus groups, evaluation, needs assessment and action research. Variations on the theme of community psychology principles and values are evident among authors, suggesting the plasticity of the field to incorporate emerging ideas. For example, in a recent book, Dalton, Elias

and Wandersman (2001), drawing on the work of Prilleltensky (1997) and other community psychologists, claimed that community psychology consists of seven core values. These were individual wellness, sense of community, social justice, citizen participation, collaboration and community strengths, respect for human diversity and empirical grounding.

The ideas of Kurt Lewin, Urie Bronfenbrenner and Emory Cowen are especially important to the field and the present research. Lewin (1890-1947) was one of the first people to acknowledge the wider physical environment in human behaviour and was the pioneer of 'action research', which may have been the "first major push in psychology toward linking scientific research with real world change" (Gifford, 1997, p.5). In 1935, he developed the famous equation: B=f (P,E) or behavior is the function of person and environment (cited in Levine & Perkins, 1997, p.114), to illustrate that the individual should not be viewed in isolation from the broader environment. Lewin proposed the term psychological ecology to describe his field of inquiry (Gifford, 1997), suggesting that action research and an ecological perspective are intimately connected.

Urie Bronfenbrenner, a developmental psychologist, further developed the ecological perspective. He used the metaphor of the Russian nested doll to illustrate the various levels of environment that surround and affect the development of an individual. According to the theory, the individual represents the inner system (central doll) and is surrounded by the outer microsystem (e.g., immediate settings such as home, school and work); mesosystem (linkages between settings); exosystem (non-immediate settings that affect the individual); and macrosystem (institutional level ideologies, organizations, culture) (Bronfenbrenner, 1979).

Emory Cowen (1926-2000) may have been the first person to use the term wellness within the field of community psychology and much of his work was explicitly or implicitly focussed around the development of a "psychology of wellness" (Cowen & Work, 1988). His writings reveal that his main interests were in primary prevention, mental health, child welfare, and wellness. Cowen's publications are numerous and only a few of the theoretical papers most relevant to the present study are reviewed here.

In an early appearance of the term wellness, Cowen (1985) discussed wellness in relation to the underlying goals of two types of person-centred primary prevention approaches in mental health. One of these was the situation-focused approach for newly

divorced and low-income single mothers. The other was the competence-enhancement strategy for developing an inner-city action center to enhance people's ability to control their own lives. Cowen argued that while there were methodological differences between these approaches, both shared the underlying goal of strengthening the psychological wellness of the population at large and therefore complemented system-level primary prevention approaches aimed at social change (Cowen, 1985). This work demonstrates Cowen's interest in community interventions as a means of bringing about social change and promoting wellness on a broad level.

The concept was further explored in Cowen's paper: In pursuit of wellness (1991). In this article, Cowen stressed the need to move away from the emphases on diagnosis and repair of established disorders to an effort on building wellness. He recognised that advancing wellness was not a simple task and required "complex and divergent solutions" that give credence to the "age and life circumstances of diverse target groups"; and consider "person related, transactional-contextual, and environmental-societal determinants" (Cowen, 1991, p.405). Cowen also identified four concepts as critical to the pursuit of wellness in the future, namely - competence, resilience, social system modification, and empowerment (1991).

Cowen viewed wellness as more than the absence of disease and was interested in wellness for all people (1994). In his 1994 paper regarding the enhancement of psychological wellness, Cowen argued that there were five essential pathways to wellness. These were: (1) positive attachments and (2) competence development in the early years; (3) positive settings that favour wellness and (4) promote empowering conditions and offer people justice, hope and opportunity; and (5) skills to effectively cope with stress (Cowen, 1994). He further argued that wellness depended on the "synergistic presence" of the five strands (1994, p.159). The paper shows that Cowen was concerned with the discovery of ideals, values or universals in wellness and the development of a model to promote it.

In his 1996 article, Cowen further developed the wellness concept and reviewed the progress of primary prevention over the previous forty years. In the article, Cowen expressed disappointment that prevention efforts tended to focus on only one of the key components of prevention - the prevention of dysfunction and not on the promotion of wellness. Cowen stressed that "a proactive approach targeted systematically toward the

enhancement of psychological wellness in all people, from the start" (1996, p.1) was necessary rather than a reactive approach to dysfunction per se.

Figure 1 was developed by the present author as a visual representation of Cowen's ideas on prevention approaches. The model takes into consideration his definition of wellness as "the positive end of a hypothetical adjustment continuum - an ideal we should strive continually to approach" (1996, p.246).

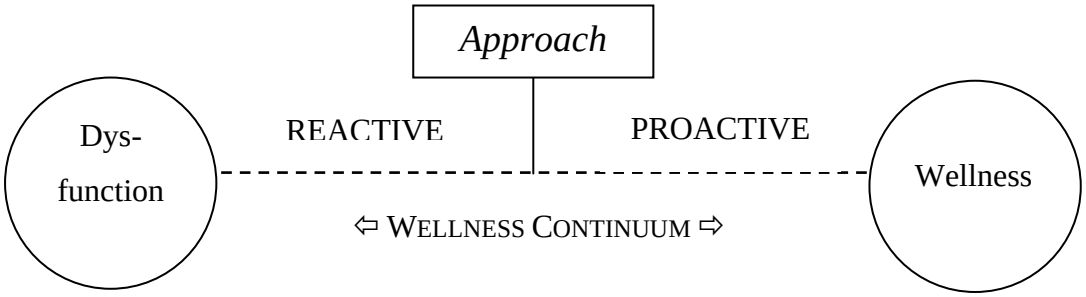

Figure 1. *The Wellness Continuum and Reactive and Proactive Prevention Approaches (after Cowen, 1996)*

Cowen further clarified the concept of wellness in 2000, outlining in detail its meaning and the sources of impact on psychological wellness and discussing education as a potential force for psychological wellness. He stated that wellness was a broad concept that could encompass many 'exemplars' but believed that the three exemplars of competence, empowerment and heightened resilience in children were most important to advancing wellness (Cowen, 2000).

Prilleltensky's community wellness model represents a furthering of community psychology theory. It encompasses many of the principles of community psychology, including the ecological perspective and the important concept of wellness. Although the term 'community wellness' is a recent word in Prilleltensky's writing (2001b), the values dimension of the model appears to have been evolving over many years. For example, much earlier work conveys criticism at how dominant psychological and social science discourses and values serve to maintain oppression in society (Prilleltensky, 1994; Prilleltensky & Gonick, 1994; Prilleltensky & Gonick, 1996; Prilleltensky, 1997). Prilleltensky and Gonick (1994) also developed a table of values

designed to reduce oppression and promote emancipation and human welfare. The model explained the meaning of the values of self-determination, distributive justice and collaboration and democratic participation in relation to reciprocal empowerment, human diversity and oppression. The importance of engaging members of oppressed groups in theoretical and practical discourse was also stressed in the article (Prilleltensky & Gonick, 1994).

Further theoretical development of the model is evident in Prilleltensky and Nelson (1997) and Prilleltensky (1997). In the first of these, the five values of caring and compassion, health, self-determination/participation, human diversity and social justice were presented in a matrix and discussed in relation to community psychology guiding concepts and the salience and social impact of the values. The values also appeared in a concentric circular model incorporating the three Bronfenbrennerian ecological levels of micro, meso and macro (Prilleltensky & Nelson, 1997). The second article consists of a set of questions to assess the moral implications of psychological discourses (Prilleltensky, 1997). More specifically, it questions whether the psychological approach promotes the five values in addition to the good life and good society; and attends to issues of power, ethics, problem definition, role of client and helper, systemic issues and prevention.

In a recent book entitled: *Promoting family wellness and preventing child maltreatment*, a hierarchical wellness model consisting of the four ecological levels of child, parental and family, community and society was proposed (Prilleltensky, Nelson, & Peirson, 2001). The model was accompanied by a table showing the particular values, resources, programs and policies that are required at each of these levels. The values of caring and protection of health, opportunities for education and personal development, self-determination, collaboration and respect for the community, support for strong community structures, respect for human diversity and social justice in the provision of resources were advanced in the book (Prilleltensky et al., 2001a).

Other Holistic Models

Similar dimensions and values have been proposed in other holistic models. For example, researchers at Ohio State University (OHU) have put forward nine key elements in their model of the ‘good community’ (2001). These included: safety, access

to needed goods and services, positive relationships that bind citizens together (or sense of inter-relatedness with others), shared values and goals, the whole person principle (being treated as a whole person), predictability (or familiarity) with one's community, opportunities for growth and fulfilment, and a degree of homogeneity (OHU, 2001).

These elements have a parallel to the values expressed by Prilleltensky and colleagues, with the exception of the latter (homogeneity), which seems contrary to our 'respect for diversity' principle. The homogeneity principle can be criticised on the grounds that it implies a pro-segregationist philosophy. For example, the article cites literature from Gans (1967) that states that while heterogeneity (of cultural diversity) adds variety, promotes tolerance, provides a broadening of educational experiences for children and offers alternatives; heterogeneity on the suburban block level leads to conflict and insoluble chronic problems. Therefore the proposition is for selective homogeneity on the block level and heterogeneity on the community level (Gans, 1967; cited in Ohio State University). However, it can be argued that the real solution lies not in segregation but in strategies and policies designed to promote a respect for each others' diversity.

Sweeney and Witmer (1991) and Witmer and Sweeney (1992) developed a holistic model of wellness and prevention over the life span. The model proposed five life tasks depicted in a wheel with spokes that are interrelated and interconnected (Myers, Sweeney & Witmer, 2000). The model was modified after factor analysis involving 3,000 people and use of the model in research and clinical practice (Myers et al., 2000). The modified wellness model consisted of sixty-one dimensions or sub tasks within the five major tasks of: Spirituality (seven subtasks); Self direction (thirty six subtasks); Work and leisure (ten subtasks); Friendship (four subtasks) and Love (four subtasks). The authors define wellness as a "way of life oriented toward optimal health and well-being in which body, mind, and spirit are integrated by the individual to live more fully within the human and natural community" (Myers et al., 2000). Interestingly though, while they acknowledge 'community' in their definition of wellness, the dimensions in the model mainly relate to the personal and relational level. It is clear that the model was intended for individual counselling rather than for broader community work and social change.

An Australian nationwide research project on the topic of citizenship and wellbeing conducted by the Victorian Council of Social Services (VCOSS, 1999) points to a potential model for promoting community well-being. The research involved ninety-eight people in fifteen focus group consultations across the country and one of the issues addressed was what makes a 'good society'. The following eight key issues emerged: safety; economic security; freedom of action; tolerance of ethnic and cultural differences; equity; good, honest, accountable government; a reasonable standard of living; and adequate information.

Another potential model for promoting community well-being comes from the Australian Bureau of Statistics. The ABS developed the framework in Table 1 as the basis for their social statistics, which according to Trewin acknowledges the OECD proposition that well-being can be measured by defining goal areas or areas of concern (ABS, 2001).

Table 1

The Australian Bureau of Statistics Model of Well-being

Aspects of life contributing to wellbeing	**Areas of concern**
Support and nurture through family and community	Family and community
Freedom from disability and illness	Health
Realisation of personal potential through education	Education and training
Satisfying & rewarding work both economic & non-economic	Work
Command over economic resources, enabling consumption	Economic resources
Shelter, security and privacy, through housing	Housing
Personal safety and protection from crime	Crime and justice
Time for and access to cultural and leisure activities	Culture and leisure

Reproduced from ABS (2001).

Wellness in a Multicultural Context

Research on wellness in multicultural communities seems scarce. Although there is a rather large body of international literature on cross-cultural well-being, life satisfaction and happiness, much of this research has been concerned with comparisons between cultures living in separate nations rather than in the same community.

Moreover, the present thesis is concerned with wellness promotion and action rather than comparison per se. Still, these studies do throw some light on the holistic nature and conceptualisation of well-being and are for this reason reviewed here.

In one such study, Deiner, Deiner and Deiner, (1995) conducted a large comparative study in order to investigate the association between subjective well-being and social, economic, and cultural characteristics of 55 nations. The aim was to identify factors that could predict the subjective well-being among these nations. Correlations between subjective well-being and characteristics of nations such as purchasing power, civil rights, GDP growth, income of neighbouring nations, income equality, individualism and ethnic diversity (heterogeneity) were conducted. The results were that only income, individualism, and human rights yielded strong associations with subjective well-being. Individualism was also classified as a strong predictor of subjective well-being.

Subjective well-being was also the focus of a study conducted by Deiner, Suh, Smith and Shao (1995) that aimed to determine differences in well-being between students in South Korea, Japan, China and the U.S.A. The domains examined included four measures of happiness as well as satisfaction with education, employment, family, finances, friends, health, housing, partner, recreation, religion, self-esteem and transportation. A general finding was that South Korea and Japan were below average in both happiness and life satisfaction and that U.S.A. was higher in both measures than the other countries.

In another study, Lee, Park, Uhlemann and Patsula (1999) conducted a study of cross-cultural happiness involving 198 Canadian students and 190 Korean students to address the question of whether people in individualistic and collectivist countries (Canada and Korea, respectively) differ in terms of their happiness. The results showed that Canadian students were significantly happier than Korean students and that different criteria contributed to their happiness. Canadian students mentioned criteria such as family, financial/materialistic wealth, and stress-free life as important to their happiness whereas Korean students mentioned the criteria of relationships with significant others, spiritual/religious life, goal/mission in life, and recognition by others (Lee et al., 1999).

The finding with regards to materialism is contrary to a recent Australian study, which found that individuals who were high in materialism were less satisfied with their

'life as a whole' (Ryan & Dziurawiec, 2000). Materialistic persons were also less satisfied with a range of other life domains, including: standard of living, family life, amount of fun and enjoyment, place of residence, accomplishments in life and health and physical condition, compared to less materialistic individuals. Cultural differences were not explored in the study.

Schyns (1998) analysed the relationship between happiness (as measured in the 1990-1993 World Values Survey) and national economic (GDP) and cultural living conditions (political and civil rights, gender equality & individualism-collectivism) for forty countries. A general finding arising from the research was that the five happiest countries were wealthy and culturally free countries (Netherlands, Iceland, Denmark, Ireland, Sweden). The five least happiest countries (India, Hungary, Romania, Russia, Bulgaria) on the other hand, were poor and restricted countries. According to Schyns, the significant relationship between happiness and both economic prosperity and cultural conditions agrees with Maslow's (1970) 'needs theory' which holds that a good life is largely determined by the amount of need satisfaction; the more needs are satisfied, the happier people will be (Schyns, 1998).

Conversely, unmet needs may lead to disadvantage and may be seen as the opposite end of the continuum to a good life, happiness and wellbeing. The Australian Department of Immigration and Ethnic Affairs (now Department of Immigration and Multicultural Affairs) lend support to this argument. According to this department disadvantage is not synonymous with characteristics such as ethnicity, low socio-economic status or Aboriginality but comes about when society and its institutions do not adequately respond to the diverse needs created by such characteristics (1986). Therefore, part of what we do to improve community well-being must be about identifying and addressing diverse community needs. However, another important aspect to any wellness enhancement or community improvement strategy is to search out and promote existing 'strengths' (Reardon & Welsh, 1993; Weil, 1996; Prilleltensky, 1999; Myers et al., 2000; Dalton et al., 2001; Prilleltensky, Nelson & Peirson, 2001). Needs and strengths are discussed further in the following theoretical chapter.

CHAPTER THREE

Wellness Praxis

Three main theories informed the present study. These were the community wellness model (Prilleltensky, 2001a), needs theory (Roth, 1990) and the cycle of praxis (Prilleltensky, 2001b & c). The three theories were integrated and together may be referred to as the Community Wellness Cycle of Praxis. This model provided both theoretical and methodological guidance to this study and is discussed further below.

Community Wellness Model

Prilleltensky's (2001a) community wellness model is presented in Table 2. The symbols in the top row were added to assist the readers' understanding of the theory. The essential features of the model are the three *levels* (personal, relational, collective); the various *items* or *values* contained within these levels; and the assumption that wellness is not just one or the other but a *synergy* of personal, relational and collective well-being. For example, good physical health does not equal wellness in the presence of discrimination at the relational level and lack of opportunity for economic security at the collective level.

Table 2

Prilleltensky's Community Wellness Model: A Synergy of Personal, Relational and Collective Well-being (2001a)

Community Wellness Model	Personal	Relational 	Collective 
	Sense of control over one's life, physical health, love, competence, optimism and self-esteem	Social support, affection, belonging, cohesion, collaboration, respect for one's diversity and democratic participation	Economic security, social justice, adequate health and social services, low crime (safety), adequate housing and social structures (e.g., educational, recreational and shopping facilities) and a clean environment

Indeed social injustices such as these can lead to apathy, feelings of incompetence, pessimism, low self-esteem and other psychological and social problems. This example demonstrates the logic of the statement that: “there cannot be wellness but in the combined presence of personal, relational, and collective wellbeing” (Prilleltensky, 2001a, p.8).

Praxis

There is often a gap between theory and practice that is difficult to bridge. This was certainly the feeling during the conceptualisation stage of this project when thinking about how to apply the community wellness model in research with diverse community members. The community wellness model may be important in terms of both theory and practice because it draws our attention to multiple needs that could be addressed; but it lacks a prescription for how this could be done. The action research method and concept of praxis are central to this dilemma.

The term praxis (πραξι) means action in Greek (Hionides, 1987). However, the term is most often used in reference to the combination of both theory and action following Aristotle’s reasoning that both praxis (action) and theoria (theory) are important (O’Brien, 1998). Seng (1998) offers a summary of the historical basis and usage of the term in the following quote:

> From Aristotle through the Medieval Scholastics, and on through Kant to Marxist philosophers of science and political economy in the 19th and 20th centuries, praxis has to various extents implied an integration of theory and practice. The term is invoked to juxtapose with "pure reason" which is objective and abstract, disconnected from practical concerns (Bottomore, 1983, p.436). Today, the word praxis appears often in feminist and critical discourse. It connotes activism and consciousness about one's work, drawing on the politicizing of the philosophical term by Karl Marx (1977) and Paolo Freire (1970). Key elements in the modern and postmodern historical development of the concept of praxis include integrating practice and theory, combining reflection and action, working with "the people," and working to cause change (Seng, 1998, p.4).

O'Brien (1998) suggests that praxis and action research are not the same construct in his claim that action research is a method while praxis is a *research paradigm*. He also claims that action research belongs more rightly (epistemologically) to a praxis research paradigm than to either a positivist or an interpretive research paradigm (O'Brien, 1998). The logic in this statement can be understood when one considers that while the positivist paradigm is mainly concerned with objective fact finding, and the interpretive paradigm is concerned with the discovery of subjective meanings, praxis is about vision and action.

Several other theorists have identified three types of action research, including McCutcheon and Jurg (1990) who distinguish between a positivist perspective, an interpretivist perspective and a critical science perspective (cited in Masters, 1995); and McKernan (1991) who distinguishes between the scientific-technical view of problem solving, practical-deliberative, and critical-emancipatory, action research.

Action research as a 'method' involves a cycle of various stages or steps, which begins with some kind of reflection and leads to some kind of action. One such model by Grundy and Kemmis (1981) consists of repeating cycles, with four steps (plan, act, observe and reflect) in each cycle. Another more complex model developed by Susman (1983) consists of five phases beginning with problem identification or (diagnosis); considering alternative courses of action (action planning); selecting a course of action (taking action); studying the consequences of an action (evaluating); and identifying general findings (specifying learning). This five stage cyclic process is repeated until the problem is resolved.

Prilleltensky (2001b) has also developed a cyclical action model - one that is woven in with critical theory and the concept of praxis. According to him, praxis refers to a cycle of activity that includes philosophical, contextual, needs, and pragmatic considerations (Prilleltensky, 2001b). The cycle of praxis begins with philosophical considerations about values that are capable of promoting personal, collective, and relational wellness; or what is also referred to as the *ideal* vision or what should be? The cycle continues with research on needs (or what is missing?) and contextual factors (actual state or what is?) and ends with pragmatic (what can be done?) considerations for action (Prilleltensky, 2001b).

Needs Theory

The model shares some methodological parallels with a needs assessment as defined by Roth (1990). Roth's conceptualisation of need consists of a lineal equation that can be used in the design of a needs assessment. According to Roth, need (N) can be defined as the discrepancy between a target state (X) and an actual state (A) as expressed in the equation: X–A=N. The target state (X) in the above equation can represent an ideal state, a norm, minimal satisfactory state, desired state, or expected state (Roth, 1990). As may be compared, Prilleltensky's (2001b) value-based cycle of praxis reflects three similar components with the additional component of 'action'.

Theoretical Integration

Figure 2 shows a synthesis of Prilleltensky's Cycle of Praxis and concept of community wellness (2001a, b & c) in light of Roth's (1990) needs equation. This model has been adapted from Prilleltensky's previous praxis diagram (2001c), by adding mathematical signs and labels that are specific to the concept of community wellness. The result of this synthesis is a cyclical equation which can be expressed as I-N=S+A=I; where (I) are community wellness Ideals or values; (N) are Needs or needed elements of well-being; (S) are existing wellness Strengths or resources; and (A) is Action to address needs. The equation may be remembered by the acronym INSAI (pronounced *in-sigh*).

Expressed in numbers, the equation may be stated as: 10-3=7+3=10 (INSAI); or alternatively, as: 10-7=3+3=10 (ISNAI). This means that if 10 was an ideal state of affairs in terms of community wellness but the community was assessed as a seven in terms of their overall state of wellness or existing strengths, then this would point to three needs and subsequently three actions that would have to be undertaken to improve wellness in the community. These three community needs could be issues such as high unemployment, lack of a community centre and racism. Therefore, needs are the negative or missing aspects while strengths are positive and existing indicators of community well-being (e.g., low crime, adequate educational facilities, good health).

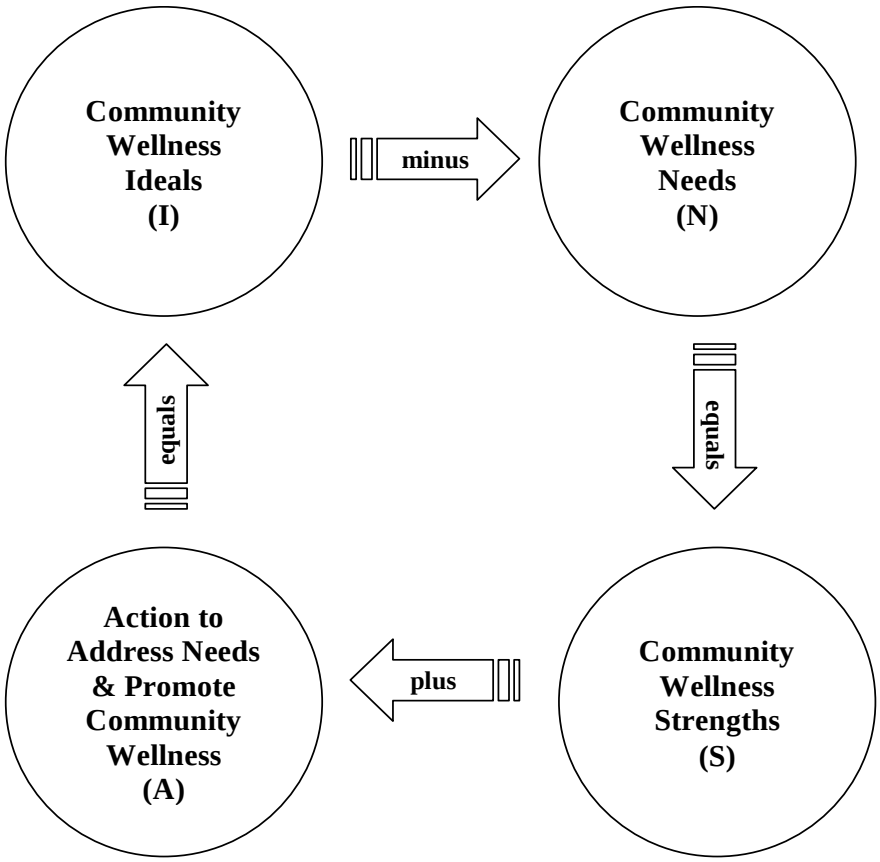

Figure 2. *The Community Wellness Cycle of Praxis: A Synthesis of Theory and Method (Adapted from Prilleltensky, 2001a, b & c)*

The praxis model forms a useful theoretical and methodological framework for the present study. While the emphasis of this study was on the community wellness Ideals, Needs and Strengths of community members, the study was designed with a view to what Actions could be undertaken to promote wellness. Roth's symbols and definitions are summarised in Table 3 together with the corresponding parameters of the current theory.

Table 3

Parameters of Roth's Need Theory and the Present Theory

Roth's Need Theory		Present Theory	
Symbol	Definition	Symbol	Definition
X	Ideal. Norm. Minimal. Desired. Expected.	I	**Ideal**. Value. Holistic Well-being. Wellness. Synergy. (What should be?)
A	Actual state.	S	**Strengths*** - actual or existing. (What is?)
N	Goal discrepancy. Social discrepancy. Essential discrepancy. Want (desired discrepancy). Expectancy discrepancy.	N	**Needs**. Negative or missing elements for well being. Disadvantage. (What is
		A	**Action** to address needs & promote wellness. (What can be done?)

Note. Table adapted from Roth (1990); Prilleltensky, (2001b). *It makes more sense to use the term 'strengths' as opposed to 'actual state' because in reality an 'actual state' can consist of both positive (strengths) and negative (needs) aspects. However, in proposing an equation consisting of the ideal, actual and need, it is clear that Roth implied an existing positive by the term.

Whose Ideals or Values?

The top left circle in the praxis model entitled 'Community Wellness Ideals' (see Figure 2) begs the question: Whose ideals or values do we strive to achieve? Since questions about dogmatism and relativism are frequently raised in discussions about values (Bernstein, 1983; Bauman, 1993; Kane, 1994; Prilleltensky, 2001b), it is appropriate to discuss these concepts in relation to the community wellness model. Prilleltensky (2001b) and other authors acknowledge that imposing a dogmatic set of values onto people undermines human diversity (see also Taylor, 1992; Trickett, 1996). Extreme relativism on the other hand stifles action because its underlying message is that we can never have a common vision to strive for.

A more balanced approach to this paradox of extremes is that: "Values should avoid [both] dogmatism and relativism" (Prilleltensky, 2001b, p.750; italics added). While the present research holds a pre-existing set of ideals or values it should be recognised that the community wellness model is not a dogma to be imposed on others. Rather, it is a framework to compare and assess community members' own ideals,

strengths and needs. It is also recognised that while ideals, strengths and needs may be personally or culturally relative; common ideals and values among people can also be expected. It can be argued that the stance taken in the present context is neither dogmatic nor relativistic. Researchers should not pretend that they are empty vessels without pre-existing values, knowledge and theories about what people might need in order to be well, but they must be aware of their own idiosyncrasies and be willing to test and refine their assumptions in light of emerging contradictions and viewpoints.

Acknowledging that participants are the experts in their own lived experiences does not demand that that researchers 'throw out the baby with the bath water', that is, their own expertise. Curtis, Bryce and Treloar (1999) point to an answer to the question posed at the beginning of this section (Whose ideals or values should we strive to achieve?) in their statement that the development of options and definitions of effective change is a product of collaboration and negotiation between both researcher and participants (1999). Researchers, community service providers, policy makers and other professionals must therefore reflect on what they believe people need for well-being as well as on what community members say they need. This will ensure the appropriateness of the intervention.

Aims and Research Questions

The major aim of this study was to employ the Community Wellness Cycle of Praxis in qualitative research with diverse community members from the St Albans region in order to gain a theoretical and practical understanding of well-being from a multicultural perspective. Specific research questions were:

1. What are the community wellness ideals (a); needs (b); and strengths (c); of St Albans community members?

2. What actions can be undertaken to improve well-being in this community?

CHAPTER FOUR

Methodology

Overview of Methods

The research involved a total of 31 people (17 females & 14 males) and included a pilot interview with a Maltese woman, four focus groups with Maltese, Vietnamese, Anglo and Italian community members, and a further individual interview with a Serbian woman. Ideally, community research should include minorities as well as the major cultural groups who reside in a region. I had originally planned to conduct more individual interviews with culturally diverse persons but the research from the above sample generated a rich amount of data for a thesis of this scope and was sufficient to explore the framework.

Personal Background

It is important in qualitative research to discuss one's personal interest and position as the research instrument (Maxwell, 1996). As a community psychology student, I was very pleased to be offered the opportunity to work within the Community Wellness Project. The project espouses many of the principles and methods of community psychology while at the same time having interdisciplinary relevance.

The community wellness model is a guide to ecological understanding and action. A practical example of an ecological approach can be drawn from my experience in a short term contract and student placement with an agency called ADEC (Action on Disability within Ethnic Communities). ADEC worked on multiple levels as suggested in the community wellness model. This included advocating for disabled and elderly individuals at the personal level; supporting their carers and providing community education and service provider training on disability and cross-cultural issues at the relational level; and affecting government policy at the systemic or collective level. I believe that working at multiple levels to solve community problems may be the service delivery model of the future.

Part of my work at this agency involved locating, examining and writing abstracts (for a website) on research related to the Home and Community Care (HACC) service needs of non-English speaking background elderly and disabled persons and

their carers. An important lesson I learned about the needs assessment method was that it was an effective way of including the voices of disadvantaged persons and advocating for needed changes. Acting on peoples' self-defined needs is also a much more empowering process for the people concerned than implementing changes without their prior consultation. However, one of the limitations of needs assessments is that many of the arising recommendations are never implemented. This reflects the importance of building in the needs assessment and action/implementation phase into the one project.

The work with this agency also increased my understanding of the difficulties and barriers faced by diverse communities in accessing mainstream health and community services. These difficulties are increased when dominant members in society display negative attitudes towards cultural, linguistic and religious diversity. This background, together with my community and critical psychology orientation, interest in holistic/ecological models, values, multiculturalism, and familiarity with the St Albans region (both as a student and resident in this region) motivated me in this work.

Rationale for Qualitative Methods

Qualitative methods were considered more appropriate for this study than quantitative methods. Firstly, given that well-being has not been explored using this framework before, it was more logical to adopt a qualitative inquiry mode rather than a quantitative model. It could be argued that quantitative methods (e.g., surveys) are more suited to research where the parameters of a construct are already known and when the concern is with magnitudes and statistical differences rather than qualitatively different views on the meaning of well-being. Qualitative changes in well-being due to changed conditions, community events and government policies are also difficult to ascertain using quantitative methods. For example, a quantitative measure could tell us that person one was less satisfied in the 'housing' and 'income' domain than person two but not that person one was recently evicted because he could not pay the rent. Thus, qualitative methods were deemed more conducive to discovery in the present context.

Focus group methods were especially relevant to the topic of 'community' wellness or wellness 'beyond the individual'. Participants in focus groups were also able to interact with each other. Where this sometimes meant participants disagreed and

criticised each other's comments, it also allowed them to learn from and console each other. The research gave voice to participants in a way that could not be achieved with quantitative methods.

Quantitative (survey) methods using the community wellness framework and larger samples could yield valuable information regarding community well-being in the future. However, the model needs to be explored in depth and in a relatively unstructured way before sufficient theoretical material for such a measure can be obtained.

Interview and Focus Group Participants

The pilot interview involved a 39-year-old Maltese-Australian woman from the Western region of Melbourne who migrated to Australia over 30 years ago. She was known to the researcher and recruited because she could offer feedback on the interview questions and the interviewers style. Following advertisement of the study to agencies in the St Albans region (see flyer in Appendix B), one of the local service providers introduced me to a 19-year old Serbian-Australian woman who was interested in participating in an interview. This participant had lived in St Albans for four years and migrated to Australia just six years ago.

Table 4 shows the numbers, gender, ages and migration details of research participants. The participants for the Maltese, Vietnamese and Italian focus groups were recruited by a key community member from each of the respective cultural groups - following personal consultations between the key person and myself over a number of weeks. Three people were referred for the Anglo-Australian focus group by Good Shepherd staff; while another four Anglo-Australian persons were recruited from the St Albans shopping precinct, following a personal invitation by my colleague (Robertson). A total of twenty-nine people aged between 18-70 participated in the focus groups. All but one of the participants resided in the Brimbank region with twenty-six from St Albans and Sunshine and one from Taylors Lakes. The participant who lived outside the Brimbank region had strong cultural links and friendships in St Albans. The Anglo-Australian participants were all born in Australia while the other three groups migrated to Australia between 6-42 years ago.

Table 4

Characteristics of the Interview and Focus Group Participants

Method	**Number & Gender**			**Age Range (& Mean)**	**Years Since Migration (& Mean)**
	Female	*Male*	*Total*		
Interviews					
Maltese	1	-	1	39	30
Serbian	1	-	1	19	6
Focus Groups					
Maltese	5	2	7	46-55 (47.4)	22-38 (31)
Vietnamese	2	6	8	18-25 (21.5)	6-24 (18)
Anglo	4	3	7	20-47 (31.4)	-
Italian	4	3	7	50-70 (60)	25-42 (36.7)
Totals	17	14	31	18-70 (40)	6-42 (27.95)

Participants' religions included Catholic (58%), Buddhist (19%), other Christians (10%), and 13% undecided or not stated. Nearly 10% of participants had only a primary school education, 29% attended 1-5 years of secondary education, 26% completed secondary school, six percent completed secondary and some form of other training, 26% had a university degree and one person (3%) was undertaking post-graduate studies.

Materials

A plain language statement, a consent form, a page consisting of 16 demographic and background information questions (e.g., gender, age, country of birth, culture) and a semi-structured questionnaire/interview schedule were developed for use in the research. Blank copies of these may be viewed in Appendix C. The schedule was composed of four sections or themes (A-D) and ten questions and is presented in summary form in Table 5 (first column). Table 5 also shows the corresponding parts of the praxis model (ideals, needs, strengths and actions) and research questions (column two).

Table 5

Questions Employed in the Interviews and Focus Groups, Parts of the Praxis Model and Research Questions

Interview and Focus Group Questions	**Praxis Components & Research Questions**
Section A: The meaning of well-being and the lack of/or opposite of well-being 1). What does well-being mean for you? **2). What does the lack of/or the opposite of well-being mean for you?**	**IDEALS** 1.a. What are the community wellness ideals of St Albans community members?
Section B: Positive things about your present state of well-being 3). What is good about your present state of personal well-being? 4). What is good about your present relationships with other people? 5). What is good about the present conditions in your life and community?	**STRENGTHS** 1.b. What are the community wellness strengths of St Albans community members?
Section C: Negative things about your present state of well-being 6). What is not so good or missing for your personal well-being at present? 7). What is not so good or missing in your present relationships with other people? 8). What is not so good or missing in terms of the present conditions of your life and community?	**NEEDS** 1.c. What are the community wellness needs of St Albans community members?
Section D: Actions or changes that could improve well-being in St Albans 9). What are some of the things that you and other people who live in St Albans could do to improve well-being in the community? 10). What could other people (health and community service workers, governments, researchers) do to help us improve well-being in this community?	**ACTIONS** 2. What actions can be undertaken to improve well-being in this community?

It should be noted that the order of questions on the theme of needs and strengths is different to the praxis model. Needs were discussed after strengths to stimulate more discussion of the following 'action' questions. It seemed logical that participants would have more to say on what actions could be undertaken after reflecting on the negative or missing elements of their well-being. Also, the term 'well-being' rather than 'wellness' was used as it is a more familiar term among lay persons.

The pilot individual interview revealed that the questions were understandable and could generate meaningful discussion about well-being. The general structure of the interview schedule was therefore not changed, although some questions were slightly reworded to improve clarity. Some further prompts were also developed.

Procedure

The research commenced following approval by the Department of Psychology Research Ethics Committee at Victoria University of Technology, St. Albans. The ethics approval note is attached as Appendix D. Approval was gained following the undertaking of slight modifications to the original research plan as recommended by the Ethics Committee Reviewers. The pilot interview was conducted in the participant's home while the other individual and group meetings were conducted at GSYFS. Written approval to conduct the meetings at GSYFS was obtained from the manager of the agency and can be seen Appendix E. The procedure for individual interviews involved reading information about the study to the participant, obtaining signed consent and asking the two general questions about well-being. Following the first two questions, a simple colourful diagram illustrating the personal, relational and collective levels was shown to the interviewee (Appendix F). At this point, a copy of the schedule was also given to the interviewee to assist understanding and memory of the questions and framework. The value items of the model were not shown or discussed with the participant so as to avoid biasing the research.

Each focus group session began with informal conversation and introductions over morning tea to facilitate discussion between participants. Name-labels were distributed, and the format of the session together with matters of confidentiality, privacy and other rights were explained when participants were seated. Participants were also informed that differences in opinion about well-being were common and acceptable and that well-being could mean something different to a man or woman, a younger or older person or to someone born in Australia or in another country. The questions were presented both verbally (Totikidis) and visually using transparencies and an overhead projector by my colleague (Robertson). Brief notes of the responses were written on the transparencies during the discussion for participants to see and reflect on

(Appendix G). Once again the levels of the model were introduced to participants after the first two questions by means of a colourful diagram.

Five minutes was originally allocated for each of the ten questions. However, focus groups took considerably longer (up to 90 minutes) than the individual interviews (about 45 minutes). All the meetings were tape-recorded. Participants were asked to complete the demographic/background questions at the end of the discussions and a monetary gift of twenty dollars was given to each participant.

A social work student and a PhD (psychology) student were hired to produce verbatim type written transcripts from the audio tape recordings for the purpose of qualitative analysis. All the transcripts were checked for accuracy (by means of reading and listening to the audio tapes) by the author prior to analysis.

Data Analysis

The analysis of data was guided by the praxis model components and the research questions developed from these components. The data analysis therefore attempted to explicate participants' ideals, strengths and needs as well as possible actions that could improve well-being in the community. Ideals are discussed in chapter six while strengths, needs and actions are discussed in the concluding chapter.

Although further information on the data analysis methods used to explicate each research question appear in the findings and discussion chapter, a conceptual matrix that guided the initial analysis of the first question on *ideals* is introduced in Table 6. As reflected in this table, the items of analysis were the responses from transcripts, audio recordings, overhead transparencies and interview notes for each focus group and interviewee (see columns 1&2) while the personal, relational and collective ideals of participants, were the foci.

Five summary tables (Tables 7-11) were produced to illustrate participants' personal, relational and collective ideals. The construction of these tables involved careful examinations of transcripts and other items to extract the *essence* of what participants said about well-being and thus are not merely descriptive. A table showing the common themes that emerged among community members as a whole (Table 12) was also developed following further examination of the tables, transcripts and other items. Participants' values for each common theme are further demonstrated with excerpts from the transcripts and also appear in the next chapter.

Table 6

Conceptual Matrix Guiding the Analysis of Wellness Ideals

Analysis	**Participants**	**Well Being**			**Table**
		Personal	Relational	Collective	
1	Maltese Focus Group	✓	✓	✓	7
2	Vietnamese Focus Group	✓	✓	✓	8
3	Anglo Focus Group	✓	✓	✓	9
4	Italian Focus Group	✓	✓	✓	10
5	Individual Interviewee (Maltese woman)	✓	✓	✓	11
6	Individual Interviewee (Serbian woman)	✓	✓	✓	11
1-6	Common Themes	✓	✓	✓	12

Unlike the analysis of ideals, participants strengths and needs were ‘identified’ but not examined in an in depth way. In addition to the word restrictions of a minor thesis, a conceptual reason for not treating strengths and needs in the same way was that the exposition of ideals also reflected (or subsumed) strengths and needs and so further discussion would have resulted in repetition. Moreover, as implied in the praxis model, strengths and needs are the existing and missing elements of well-being. These may be of interest on their own but the practical value in determining strengths and needs is that it enables the identification of actions that may be undertaken to improve community well-being.

CHAPTER FIVE

Findings and Discussion

The presentation of findings in this section was guided by the research question (1a): What are the community wellness ideals of St Albans community members? This chapter therefore focuses on ideals while strengths, needs and actions are dealt with in the concluding chapter.

Community Wellness Ideals

Participants' responses from all sections (A-D) and questions (1-10) of the interview schedule were examined in order to address the research question on community wellness ideals. This involved reflecting on the research, listening to the audio-taped responses and reading the transcripts, notes and transparencies (the latter were only used in focus groups). From this, concepts or factors that could be classified as ideals were entered into five tables, one for each focus group and one for the individual interviewees.

Some of the factors stated as opposites of well-being were also included in the tables by rephrasing in the affirmative. For instance, if 'a lack of self esteem' was mentioned as an opposite then self esteem was the ideal or affirmative. In this way, both directly stated and implied ideals could be included in the tables.

Maltese-Australian Ideals. The wellness ideals of the Maltese-Australian group are shown in Table 7. Personal well-being for this group consisted of physical health, spirituality and a wide range of positive feelings and characteristics while extended family, cultural maintenance and friendly relations with other cultural groups in the community emerged as important values for relational well-being. Some of the collective issues of importance to this group included adequate infrastructure, services and policing of crime and safety, ethnic clubs and services for elders and responsive local government.

Table 7

Summary of Community Wellness Ideals Among the Maltese-Australian Group

Personal Well-being
Physical and mental health. Positive thinking. Self-esteem. Confidence. Control. Healthy mind, body & soul. Faith/spirituality. Inner peace (vs. inner conflict). Self-acceptance. Learning Opportunities. Happiness. Contentment. Authentic self. Coping ability. Resilience.
Relational Well-being
Caring for others. Feeling connected. Good relationships with partner, family & extended family. Community acceptance of cultural diversity. Relationship with God. Intercultural cohesion & mingling (vs. cultural segregation). Community participation and protest. Responsibility. Not blaming others. Cultural maintenance or connection to roots. Respect for elders needs.
Collective Well-being
Adequate infrastructure: education, hospitals, shops, higher education, employment, transportation, ethnic clubs & services for elders. Clean environment (no rubbish & beautification). Multicultural church. Responsive local government. Adequate parent, family & mental health support services. Adequate policing – crime & safety. [Egalitarian] government funding to community.

Vietnamese-Australian Ideals. The ideals of the Vietnamese-Australian participants may be seen in Table 8. The table shows many positive emotions and characteristics valued by this young group of Vietnamese people. Ideals related to the personal domain included holistic health, adjustment, happiness and satisfaction with life. Relational ideals included positive relationships with friends, family and others, safety, no racism and positive community relations. Ideals within the collective theme include adequate opportunities for education and employment, community information and a range of community and cultural resources.

Table 8

Summary of Community Wellness Ideals Among the Vietnamese-Australian Group

Personal Well-being
Health: physical, psychological, mental, spiritual and social. Secure (supportive) family. Not having fear. Positive sense of identity. Success. Self-esteem. Cultural integration (mental). Positive adjustment. True happiness. Satisfaction with life. Education. Hope, faith and motivation. Satisfaction of basic needs (food, rest, shelter, procreation).
Relational Well-being
Safety. Feeling accepted in the community. Supportive social group. Strong identification with friends. Tolerance. Good communications – family and others. Reciprocal relationships. Positive peer relationships. Trust. Understanding. No racism/stereotyping. Intercultural interactions/integration (vs. cultural segregation). Part of community. Sense of belonging (community). Kindness to others.
Collective Well-being
Social well-being: being able to walk out on the street freely. Adequate meeting places. Community festivals and cultural events. Being informed about the community. Adequate opportunities (e.g., career, education). Adequate education and hospitals. Quality teaching/mentoring. Services to accommodate elders and diversity. Temples and churches. Funding to local community groups. Policy response to gambling. Information regarding services to NES people. Employment: basic human right. Responsive/representative government.

Anglo-Australian Ideals. Table 9 shows the wellness ideals of the Anglo-Australian group. People in this group value health and emotional well-being, and a range of positive feelings and characteristics such as self-esteem, happiness, feeling safe and self acceptance. Equality, no discrimination, kindness and respect were raised as important ideals within the relational domain. Many cultural and community issues were also discussed. The group were critical of the broader collective that they live in and identified many resources and responses of importance to their collective well-being.

Table 9

Summary of Community Wellness Ideals Among the Anglo-Australian Group

Personal Well-being
Health. Emotional well-being. Self-esteem. Free will. Empathy. Feeling good. Feeling safe. Happiness. Loving yourself [self-acceptance]. Not being greedy. Fun. Realistic expectations. Trust. Caring.
Relational Well-being
No discrimination. No racism or racial conflict among youth. Kindness to others. Respect for everyone. Golden rule. Not having fear of others. Trust with partners. Compromising. Joy from watching children grow. Political participation by community. Cross-cultural communication. Community spirit. Community cohesion (vs. individualism). Connectedness. Cultural integration. Cultural reconciliation.
Collective Well-being
Employment. Equality**.** Safety. Adequate income. Access to free legal services. Home ownership. Drug free kids. Staying alive in St Albans [no racial or turf wars]. Awareness of global issues/ecology. Fair system. Good (non tokenistic) government. Access to support services: centre link, housing, transport. Adequate response to community issues: drugs, gambling, smoking, violence, graffiti, dental health care, education, GST burden, poverty trap, rich/poor gap, cost of living, employment.

Italian-Australian Ideals. The community wellness ideals of the Italian-Australian focus group participants are presented in Table 10. This older group of people mentioned many physical factors as important to their personal well-being (e.g., health, work, activities, absence of pain) as well as a few other values such as love, faith, religion and spirituality. Relational well-being for this group meant having an understanding

Table 10

Summary of Community Wellness Ideals Among the Italian-Australian Group

Personal Well-being
Good health. Good life. Love. Maintaining activity levels through physical work and recreation. Not having pain. Realistic expectations regarding pain/ageing. Pleasant distractions from boredom and pain. Balance between home/external activities. Not being isolated. Coping with death of loved ones. Faith, religion and spirituality.
Relational Well-being
Family health and well-being. Understanding partner. Strong (extended) family connections. Celebrations with family. Respectful relationships. Reciprocal relationships with adult children (not being taken for granted). Caring/helping others. Friendship. Social activities. Cultural maintenance and contact with own culture. Good relationships with neighbours.
Collective Well-being
Adequate support for migrants. Safety in community. Safety on transport. Policing of drug risks to residents and crimes against elders. Adequate recreational facilities. Support/funding for ethnic elderly clubs, churches. Adequate response to vandalism. Adequate shopping facilities – variety and ‘quality’ shops. Education for responsible adolescence (re: respect, morals, graffiti, vandalism). Employment for this area. Availability of specialist services (e.g., optometrist).

partner and having good relationships with extended family, friends, culture and neighbours; but interestingly, the broader community of persons were not mentioned. Collective issues included the need for greater support, services and safety for this older group of persons. The education of adolescents (re: respect, morals, graffiti, vandalism) was also raised as an issue of concern to people in this group.

***Ideals of the Individual Interviewees*.** The ideals of the Maltese and Serbian interviewees are summarised in Table 11. As shown in the first row, some of the personal characteristics valued by the Maltese interviewee were good health, absence of pain, feelings of peacefulness, sense of control and spirituality. Issues of importance to her on the relational level included her son behaving well and maintaining contact with her close friends and family. She also had a concern about individualism and materialism in the broader community. Collective ideals included basic financial security, safety, health care and good government.

Table 11

Summary of the Community Wellness Ideals of Individual Interviewees

Personal Well-being	**Relational Well-being**	**Collective Well-Being**
Participant 1: Peaceful. Not worried. Feeling relaxed, not nervous, not stressed, comfortable. Well organised. Control. Physical health and absence of pain. Spirituality. Transcendence.	Children behaving well. Good friendships. Many friends. Good relationships with immediate and extended family. Democratic participation. Loving partner. Sense of community (vs materialism, individualism and over competitiveness).	Financial security: (money, property, car). Good government - responsible, effective, honest, democratic. Free health care. No GST. Low crime rate - safety.
Participant 2: Physical and emotional health. Emotional strength (ability to cope with stresses and problems). Confidence. Feeling complete. Education. Self care. Happiness.	Loving parents and family. Communication with neighbours. Respect for diversity (of culture and personality). Tolerance and friendliness with others. Multiculturalism. Collectivism (community).	Basic necessities (roof over head). Peace. Safety. Low crime. Adequate parks, gardens and public meeting places. Good government. Community information and education. Free youth facilities (recreation and places to go).

The ideals of the Serbian participant are shown in the second row in Table 11. This participant named physical and emotional health and a range of positive feelings and characteristics associated with her well-being. As a student, it was not surprising that she also valued education. At the relational level, she felt that her loving parents and family were vital for her well-being; especially since she had the experience of

going through a war (Bosnia - 1996). The relational category shows that this participant had strong community values. Collective ideals consisted of a roof, peace, safety, adequate community structures and good government.

Common Ideals Among Community Members

Further thematic analyses of the above tables, transcripts and other materials revealed fifteen common ideals in the participants' responses. The ideals can also be referred to as common themes. These are shown in Table 12, with three classified as personal, five as relational and seven as collective. Following the table is a more detailed discussion of what community members said which includes summaries and excerpts from the transcripts to illustrate each theme.

Table 12

Summary of Community Members' Personal, Relational and Collective Wellness Ideals

Personal Ideals	**Relational Ideals**	**Collective Ideals**
1. Physical and Psychological Health	4. Family	9. Human Rights
2. Positive Thoughts and Feelings (towards oneself and others)	5. Friendship and Social Support	10. Safety
3. Spirituality	6. Intra Cultural Harmony	11. Employment
	7. Inter Cultural Harmony	12. Education
	8. Community Cohesion and Participation	13. Community Services, Resources and Information
		14. Community Development
		15. Good Government

Physical and Psychological health. A general conclusion that may be drawn is that community members viewed well-being as a holistic phenomenon that extended beyond the physical. Both interviewees and at least one participant in each focus group expressed that well-being consisted of both physical and psychological health. Participants valued both dimensions of health as exemplified in the following statement:

> ***If you're not [physically] healthy you can't continue but you also need to be emotionally strong to cope with all the stresses and all the problems (Serbian woman, age 19).***

Positive thoughts and feelings. The tables displayed in the previous section (Tables 7-11) showed that community members also named numerous positive thoughts and feelings associated with well-being. Some of the positive thoughts and feelings towards oneself were self-esteem, happiness, love, confidence, control and coping ability. Positive thoughts and feelings towards others included kindness, empathy, respect, love, caring, tolerance, trust and understanding. The following quote illustrates the importance of self esteem, confidence and coping in this man's life:

> ***To me well-being is related to my self-esteem – how I feel. My self esteem can be high and good and because of that I feel confident to deal with my wife's issues and my son's issues, you know, and my sister-in-laws problems and whatever. I feel I can cope with all of that. That is what my well-being is (Maltese man).***

Spirituality. Many participants felt that well-being also consisted of a God, spirituality or soul dimension. One woman in the Maltese focus group defined well-being as something very broad and very deep consisting of the mental, physical and spiritual. Everybody in the Maltese group seemed to agree with this definition with a second woman adding that if you are healthy in the areas of mind, body and soul then you have got well-being; if something is missing somewhere then you haven't got well-being. This closely aligns with the idea of synergy as well as with our cyclic theory of need as something missing from the ideal of total well-being. A spiritual theme is present in the following statement by a young Vietnamese man:

> ***To love one another, to help one another, is to be true to each other. That's total fulfilment I believe. I mean when you talk about religion or whatever, it's talking about being one with God, or Buddha, or who ever. It's up there at that level, above humanity, spiritual (Vietnamese man, age 22).***

Still, not everyone in the Vietnamese group had spiritual beliefs. For example, one young Vietnamese man jokingly asked whether religion and spirituality were associated with mid-life crisis. Moreover, while general support for religion was evident among the older Italian group, one of the Anglo woman implied that our way of life was constrained by laws stemming from the bible. Only one man expressed spiritual values in the Anglo group. According to this man:

You need everything [the whole] to survive and to have an idealistic life, yeah. But … the way this world is today, we can't have that. But somehow we can strive [for well-being], because we've got the God given gift of our own wills and minds to make our own decisions.

Family and Friendship and Social Support. Two relational themes that emerged during discussions with the community were family and friendship and social support. However, these themes appeared to be more important among the migrant groups and individual interviewees than the Anglo group. One migrant participant claimed that well-being for her was about the basic necessities in life. Basic necessities included physical and emotional health, a roof over her head and a loving supportive family. Her values with respect to family are clear in the statement below:

> ***Even though you may not be living in a perfect society or perfect neighbourhood, for example, if you have your family it does make you complete, and makes you feel good and loved, and also love is part of being well (Serbian participant).***

Another young migrant participant proposed a theory that stressed the importance of both the family and social group. He said that well-being was like a scale that moved up and down and that one could not expect well-being in every sphere, one hundred percent of the time. He explained that this is where security (feeling secure) in the family or social group was important. Strength in one (family or social group) could

compensate for a lack in the other and not having anyone to turn to [isolation] was what led to drug use, crime and other serious social problems among young people.

The family, both immediate and extended, were also very important for the middle-aged Maltese participants and older Italian participants. According to one Maltese woman:

> ***As for myself I think I have everything I need at the moment – I've got a husband, I've got two children. I have the rest of the family. We are all close to each other. If we have a problem we sort of talk it out, you know. I've got everything, I have my parents, they're in their 70's, what else, you know… (Maltese woman).***

Another woman from the Maltese group expressed the importance of family when she spoke at length about the joy and satisfaction of caring for her elderly mother during her last years of life. When I commented that it was a hard job to care for another person, she replied:

> ***It's hard but I enjoyed it as well and I'm glad I had that special time with mum … We shared some special moments even though it was a difficult time … I treasure the memories and I consider myself lucky to have been there (Maltese woman).***

Only one person in the Maltese group, the youngest in the group, showed a disconnection from the traditional view of family with strong support for the nuclear family form. After listening to others in the group discussing extended family, this man stated:

> ***Extended family … shouldn't have much bearing on your life I think. I come from a big family - don't get me wrong. I do see my brothers and I do see my sister, but they don't have any bearing on my life. I just have my own little circle – my wife and two kids (Maltese man).***

Family was not mentioned as much by the Anglo participants as it was by the migrant participants. Exceptions to this included a warm comment by a young mother

who replied: “My personal strength is watching my son grow” to the question about the ‘good’ aspects (or strengths) of personal well-being. Another woman replied that surviving a marriage and having her son surviving into his twenties without being on drugs were positive aspects of well-being for her.

The older Italian participants expressed strong family values. Some discussed their relationships with their grown up children and grandchildren and the following statements by two women clearly demonstrate the importance of family:

> ***For the Italian, the family is something very strong. We are not like some other families … We are very close (Italian woman).***

> ***Especially for the Italian people, la family, when it comes Christmas, New Year, Easter, Saturday, Sunday, must be stay together! (Italian woman).***

The Italian participants also revealed a strong consensus regarding the importance of social activities, especially as a diversion to the experience of pain and boredom. Two quotes on this theme appear below:

> ***If I’m thinking about [focusing on] my health, well, I have many problems but if I go out, I forget about my problems - like now, I feel good because I have company and I’m doing something that I like.***

> ***That’s why I like to go to the Italian club … I forget everything [pain]. When I go home starts again and I am sick and tired. That’s why when people go out, go around, they forget everything … So when it comes the time to retire I suggest that people must do something, go out, or join the club, go around and do something (Italian man).***

Cultural Harmony. Another theme that emerged in the research with community members can be referred to as cultural harmony. For the present purposes, I make a distinction between two types of cultural harmony. Intra-cultural harmony may be broadly defined as harmony in relation to ones own culture. This can include positive cultural identity, adjustment and self acceptance. Inter-cultural harmony may be

defined as harmony between cultures and is related to tolerance and respect for cultural diversity. The text appearing next illustrates the concept of intra cultural harmony:

> ***I am an Australian citizen. I chose to live in this country. I thank God that my parents migrated here. And, I'm also proud of my country of my birth and my roots and where I grew up (Maltese woman).***

The statement below also illustrates a clear awareness of the need to be in harmony with one's culture:

> ***I feel that we need to come to grips to [be] fully accepting of our cultural heritage because if I don't know where I've been I don't know where the hell I'm going – you're lost. I end up confused and I'll end up passing that on to my children (Maltese man).***

Another participant said that positive cultural identity and finding well-being for him was about merging two cultures together. As the following quote implies, well-being for this man is not about rejecting one culture or the other but about finding a balance between the two.

> ***Well for me, being Vietnamese and living in Australian culture … you have to try to find the balance between the two. And if you can't, you become, I think, too inclined in either culture, which doesn't work, because you can't be stuck in the Vietnamese community, and be very full on Vietnamese. Cause that's not gonna work when you actually go out (Vietnamese man, age 24).***

Respect for diversity is a vital ingredient for inter-cultural harmony. The response below shows one woman's respect for diversity and appreciation of multiculturalism.

> ***Some weeks ago we had mass and there were different languages and there were different choirs from different nationalities and it was beautiful, the mass. And then after mass there were different dancing groups dancing. It was beautiful, it was a multicultural thing … to share their culture with each other and to appreciate each other's culture and to live in peace together (Maltese woman).***

It should be noted that although the majority of participants expressed attitudes conducive to cultural harmony in the community, at least seven people out of the 31 displayed negative attitudes towards diversity. As this statement from a young Vietnamese woman suggests, inter-cultural harmony is far from adequate in the general Australian community:

> ***I probably feel comfortable sixty percent of the time … I mean there's always something you hear in the media about refugees, you know. And you go on the street and you get somebody that's a little racist, or ignorant. You know, I don't feel one hundred percent accepted [in Australian society].***

The previous comment is not surprising when one considers the anti-Asian sentiment articulated by some of the focus group participants. Many of the comments that follow were directed specifically at Asian people, although, as may be discerned, other minorities were also targeted. This points to general racial intolerance and ignorance that should be addressed in the community.

> ***Asian groceries. Asian groceries. Everyone that closes down, a new Asian grocery opens up! (Female focus group participant).***

> ***They're coming into 'our' country, with their own stuff, their own culture. And they're like, you walk down the street and there's just Chinese everywhere (Female focus group participant).***

> ***I've got nothing against the races but I think when you're in Rome do as the Romans do. I think everybody [should] intermingle. But unfortunately Asians have got their own little group, the Maltese have their own group, they're just stopping from intermingling (Male focus group participant).***

> ***It's (St Albans) like living in China Town here (Female focus group participant).***

> ***A lot of these people live in clubs – they speak their language, they live back home… I walk past every morning, there's a club just across the road here. I***

think they're Greeks and … they're playing cards, yelling in Greek. But what I'm saying about the clubs is when these Greek guys get out of the club, how do they communicate with the rest of the world? (Male focus group participant).

Who comes to this country now, it's a very large sum of money [by the government] that gives them a big head start. That's where I think that a lot of frustration is getting brought upon Australians (Male focus group participant).

I'm going back to the government side of it, about the way that the government treats these people… When the Vietnamese … come over they are actually given money. And they're allowed to work straight away. They're also given a house, and, say like a ministry type house, and within six months, they're allowed to buy it. Right? But for me to live in a ministry house, I have to live in it for five years before I get the opportunity. And I think that stinks, that sort of thing (Female focus group participant).

Community Cohesion and Participation. In the present context, the term community cohesion and participation is used in a general way to refer to concepts such as sense of community, community belonging and involvement. The first quote below explains the principle and benefit of coherence, whereas the next two imply a loss of a sense of community. The fourth and fifth quotes, while still under the umbrella of community cohesion and participation, point specifically to political participation by the community.

As a community we need … more coherence – [if] we work together, the better for us. I mean it's not for 'one' of us, but for everyone. The more we achieve as a community the better it is for us, the better environment we'll have (Serbian woman).

People's attitudes have changed over the years … there seems to be that lack of respect for each other as a community. People seem to be more arrogant. People have become more materialistic … you know, for themselves (Maltese interviewee).

> ***I don't see a community at all. I believe everyone's … [individual], I mean, all separate identities***. … ***In our culture, your neighbours are like your family. You know everyone on the whole street. But nowadays, … you just say 'Hi', that's it, you leave it there. You don't invite each other for lunches, dinners, barbeques, nothing like that. I see it as breakdown of community (Vietnamese male).***

> ***I think, generally speaking, people are apolitical … They have no interest in politics, and we need people to be interested in the political system. And the more people who are interested, you're gonna get some of those people who become very good leaders (Anglo male).***

> ***Well like everyone talks about the transport [railway problems] in St. Albans. When it comes to blockade here [protests] the same people turn up. Only 20 or 30 people turn up. If more people turn up … you know it's not enough … (Maltese woman).***

Human Rights. The term human rights seems to encompass many concepts and issues that community members said were essential for well-being. Some of these included equality, no discrimination, tolerance and acceptance. Many of the concepts referred to as 'themes' in the present context, for example, cultural harmony, safety, employment and good government can also be classified as human rights. The following statement, which fits into the human rights theme was expressed by an Anglo-Australian man when asked about the meaning of well-being:

> ***Equality … and no discrimination … and that's on all different views, not speaking [only] racially … I mean, we can have two white people in one room; one may be a drug addict, the other one may be a straight person. Now … in an ideal world, you need to cater for that addict, and we need to cater for the straight person, so therefore we have to come to some sort of compromise … People individually have to come to their own decision on their own needs and wants … and then there has to be some sort of compromise between the two.***

Safety. Another important issue for community members was safety. Many people felt unsafe in the community, which indicates the need for more policing and

crime prevention strategies. Three examples of the community's fears and concerns are included here:

> ***There is a threat of not being, well not being safe, as we go back to drug issues and wider issues. Having to lock our doors, and having to look behind our back to see if somebody's following (Anglo man).***

> ***And it's very isolated, like I walked through St. Albans the other night at 11 o'clock – there was practically no one there, no one. And one of my friends said: (in surprise) "Oh, how can you walk, you know, God, there [are] drug users, you know?" … If I'm not going to provoke them, they're not going to harm me. But I have to admit there are risks … you just never know (Serbian woman).***

> ***The safety is very bad here in St Albans. We need more police to look around because the robberies happen all the time. For the older people, some people are scared to come into the club (Italian man).***

Employment. Employment also emerged as a common theme during discussions with the community. As well as a general acknowledgement of the importance of employment for well-being, participants' said that:

- ***Unemployment was the opposite of well-being (Anglo male)***
- ***There was not enough employment in the Western suburbs (Maltese female)***
- ***Many migrants were limited to menial work because of a lack of skills (Vietnamese male)***
- ***Many unemployed people gamble in the hope of making money (Vietnamese male)***
- ***Well-being is a balance with 'all', and includes health, work/money/career, family and social needs (Vietnamese female)***

Education. There was also general consensus that education contributed to well-being. Specific topics discussed were that the quality of education in public schools was not as good as what it could be (Anglo male) and that inadequate education of adolescents led to youth crime such as graffiti and vandalism (Italian male). Two Maltese participants expressed regret about not having had the opportunity to complete their education (male and female) while a third participant in the group was glad that

her children had better educational opportunities than she had. Several people in the Vietnamese group felt that teachers were generally not very caring or inspiring. These conversations pointed to a valuing of education.

Community Services, Resources and Information. Another major theme that emerged in the research was the need for adequate community services, resources and information. Three examples related to Vietnamese migrants, youth and mental health have been selected to illustrate this theme. Further examples can be found in the previous tables as well as the table on actions in the following chapter.

In terms of this theme, one young man said that he knew a lot of Vietnamese families that were not aware of the community services that could help them. He added that other reasons for not seeking assistance, included the "pride factor" and "trust". According to this man:

> ***They're [Vietnamese people] not secure enough to go there to know that they'll be helped and assisted there. It's not knowing. But if their family or relative went there and said: "Yes! They help you out! They helped me out! I'm better off" then maybe they will be more confident of going there for assistance… There are actually pamphlets flying around, but no-one will read it. No-one will believe it. But if someone they know personally told them about it, word of mouth, then they will all go.***

As indicated in the following statement another participant felt that there was a serious shortage of recreational resources and facilities for young people in the area:

> ***When it comes to youth there aren't many places where they could go. I mean like high school students - all they have is shopping centres … They're at school till 4.00 o'clock; the school grounds get locked and what are they going to do afterwards? The shopping centre is the only place they can go to, if they are under 18. Over 18 they have night clubs and certain places. But for the younger age group there is nothing (Serbian woman, age 19).***

Another woman suggested that the mental health system was not appropriate in the area of public information and the number and range of services. According to her:

> ***I would like to make a point that we need more mental health services … Mental Health services, that's an umbrella; I mean we need more support for families who have a member of the family suffering from mental health problems, more awareness of the services that are already there … The mental health area is an umbrella which covers a lot of things not only with regards to the patients themselves, but also the families (Maltese woman).***

Community Development. Whilst the term 'community development' was not mentioned by any of the participants, most people said that there was work to be done in the community. Questions nine and ten on what could be done to improve well-being in the community were specifically designed to generate responses related to community development actions. The results of these questions may be seen in the next major section entitled: community perceptions regarding actions.

Good Government. Community members also articulated the need for good government, one that is: informative, accountable, responsible and honest. Four quotes related to this theme are presented below.

> ***Well it has become more money orientated (society) where the government just takes, takes, takes … And they keep wanting people to pay for everything and God knows what they do with it, with the extra money … It does not go back to the schools or hospitals. That sort of thing makes me upset (Maltese interviewee).***

> ***We need support from the government for the Italian people or any generation, it's supposed to be that the government or somebody else give support to give the people opportunity, to older people to go somewhere, and to enjoy themselves. Must look after this club, look after hungry people … (Italian man).***

> ***This government at the moment they do not put so much emphasis on the social side - they cost you more on economic; and the community workers … can't do much if they don't have funding. They can do what's in their hands, they can***

deal with the clients and all that. But they can't really provide programs … without money (Serbian woman).

And the Prime Minister of the country and the present Federal government are quite happy for the gulf between the 'haves' and the 'have nots' to get bigger, and bigger and bigger, and for people on low incomes, working class people - to be disenfranchised from the political system. Quite happy for that, and they're doing it by stealth and the opposition is just letting it happen. There's ineffective political leadership! (Anglo man).

Community Perceptions Regarding Actions

Table 13 shows a summary of most of the issues raised by participants in response to the final two questions on actions that could be undertaken to improve well being. Most of the items in the table could be classified under one of the fifteen themes identified. Even so, issues that did not emerge as common are not necessarily less important than those discussed by the majority. Unique or uncommon responses reflect differences among community members whereas common responses reflect similarities. This issue is discussed further in the next section.

Table 13

Community Perceptions on Actions or Changes that could Improve Well-being in St Albans

Community Action	Action by Others to Help Improve Well-being
Maltese ⇩⇨ Address transport issues. Participation in protests. Welcome newcomers. Social support for elderly. Communication with neighbours. Visiting an elderly person.	Better monitoring by council and council services (e.g., hard rubbish collection) need improving. Giving services back to certain a`reas. More mental health services needed. Awareness of services. Support for families with mental illness and more activities for people with mental illness. Social support groups. Preventative community education. Policing, reduce crime and promoting safety. Address traffic problems in St Albans. Support and help for families. Funding for beautification of region. Cleaning of public areas. Community education on environmental issues.
Vietnamese ⇩⇨ Community needs to have a special day (e.g., festival) to bring people together. Extend kindness and generosity to others. Contribute to improvement of education and hospitals.	Teaching techniques need to change. Gambling issues need to be addressed to protect peoples' livelihood. Local community groups need funding. Information about services needs to be disseminated to community. Trust and friendship between agencies and community needs to be built up and language issues need to be addressed. Better representation of community in local government. Work needed to guard peoples dignity and pride. Sense of community.
Italian ⇩⇨ Safety needs to be improved. Security. Children need to be taught about respect. Talk to neighbours. Build relationships with neighbours. Need to keep religion going.	Shopping services need improving – more quality shops and bring it closer to the people. Discount for pensioners at shopping places. Unemployment issues need to be addressed in this area. Safety of community needs to be addressed. Safety on transport. Staffing of stations. Security in trains. Broken glass on bus stops. Robberies need to be stopped. Graffiti needs to be stopped. Different religions are an issue. More discipline in schools and education on respect and morals needed.
Anglo ⇩⇨ Smile. Not judging others. Support family members and community – help one another. Community is apolitical – more people should be interested in politics. Community needs to communicate more.	Improve medical services. Address cultural integration issues. No more tokenism from government. Free dental services. Employment. Education. Cost of living for low income should be addressed. People have to have courage to speak out against bad policies. Cease fire in St Albans (conflicts among youth). Effort from migrant groups to mix.

Note. Only focus group responses are included in this table.

Similarities and Differences Among Community Members

It was not within the design of the present study to measure cultural differences in well-being, happiness, quality of life, materialism and other such constructs examined in previous studies. Establishing differences is typically a quantitative strategy that requires a large sample size and a response to each question by each participant. Common themes on the other hand, point to similarities among community members and are often the outcome of qualitative analysis. Tentatively speaking, however, the migrant participants did seem to differ from the Anglo participants in a couple of ways. Firstly, the migrants tended to place more value on family and culture whereas these themes were hardly mentioned by the Anglo group. This could be due to collectivist and individualistic values but further research is needed to determine this.

A second difference that appeared in the initial stages of the research (prior to introducing the community wellness model) was the tendency for migrants to describe well-being in personal and relational terms rather than collective terms. This should be investigated in future research as it could point to a tendency by migrants to blame self rather than recognise inadequacies in the community or political system. The community wellness model and later questions seemed to encourage participants to speak more about collective issues, which also suggests that the model may be empowering or liberating for people in this situation.

Age related differences also seemed to emerge in the research. For example, issues such as identity, career, success, acceptance and peer relationships were important for the younger Vietnamese group; family issues for the middle aged Maltese group; and coping with pain and keeping active and occupied for the older Italian group. The older group also seemed more concerned about crime and safety and the behaviour of younger people in society. The Anglo group could not be compared on age related differences due to the spread in ages in this group.

Two other issues that did not emerge in common but deserve to be taken seriously include: the need for community environmental education and beautification of the region (raised by the Maltese group) and the need for a policy response to gambling in the community (raised by the Vietnamese group).

CHAPTER SIX

Conclusions

Ideals, Strengths, Needs and Action

Two of the major theories informing this research were the community wellness model and the cycle of praxis. The former directs attention to personal, relational and collective factors in well-being while the cycle of praxis asserts that research on the ideals, strengths and needs of a community can guide future action to improve well-being. The associated equation suggests that total well-being is the ideal or goal; strengths are the existing or actual resources; and needs are the missing or needed elements of well-being. The name Community Wellness Cycle of Praxis was given to refer to the integration of these theories. The study aimed to employ this model to gain a theoretical and practical understanding of well-being from a multicultural perspective.

One of the major research questions was: What are the community wellness ideals (a); needs (b); and strengths (c); of St Albans community members? Fifteen community ideals were identified and discussed in the previous chapter in relation to the first part (a) of this question. Although it is not possible to discuss the strengths and needs of every participant or to generalize to the rest of the community, some tentative conclusions can be also be drawn about the latter part of the question (part b & c). On the whole, it may be concluded that of these 15 ideals, items one to six were areas of strength for this community while items seven to fifteen were areas of relative need.

Community strengths and needs are shown in Table 14. These needs and strengths were determined by assessing whether the responses related to each of the 15 themes were positive and satisfied or negative and dissatisfied. For example, the comment about ineffective political leadership and the widening gap between the ‘haves and have-nots’ is obviously negative and dissatisfied. Such comments by community members therefore point to the need for more responsive or Good Government for the community. Alternatively, recognizing that the system is not as effective as it could be and having personal concern about such issues also demonstrates the strengths: Psychological Health and Positive Thoughts and Feelings (e.g., intelligence, astuteness, values of social justice, concern for the poor and leadership qualities). The fifteen strengths and needs themes are all reflected in the quotations in the previous chapter on

ideals, and thus will not be repeated here. The recommendations arising from these findings are discussed in the following section.

Table 14

Community Strengths and Community Needs

Strengths	Needs
Physical and Psychological Health	Inter Cultural Harmony
Positive Thoughts and Feelings (towards oneself and others)	Community Cohesion and Participation
Spirituality	Human Rights
Family	Safety
Friendship and Social Support	Employment
Intra Cultural Harmony	Education
	Community Services, Resources and Information
	Community Development
	Good Government

Action to Improve Well-Being

The second research question was: What actions can be undertaken to improve well-being in this community? The ideals, strengths and needs that were identified in this research in consideration of the actions for improvement suggested by community members, make a suitable guide for community development and action in St Albans. The common tables referring to ideals, strengths and needs (Table 12 & 14) give a general indication of where to direct our efforts. The more specific tables (7-11 & 13) show particular issues raised by the cultural groups involved (Anglo, Italian, Maltese and Vietnamese) while many of the excerpts also show specific issues of concern to community members. Given that the present study was exploratory and involved only a small part of the community, the tables could be used as the basis for further research with community members. This does not mean that action to improve well-being cannot proceed but rather that there are other views in the community that should also be expressed. In light of the findings of this research, it is recommended that:

- Culturally appropriate family services and support to migrants are set up in the community

- Information regarding existing community services, resources and benefits are disseminated to migrants
- Mental health and other services in the area be strengthened and made more accessible
- Strategies and community education to curb negative attitudes and promote harmony be implemented in this multicultural region
- Local government, policy makers and community workers engage in ongoing consultations with the community to resolve community problems
- Policing of certain areas is increased and crime prevention and community safety measures be further implemented
- Business and employment to the area be developed
- Community events, celebrations and festivals be valued and encouraged
- Elderly clubs are supported and adequately funded
- Youth services, recreational activities and opportunities be improved and extended
- Affordable education and learning opportunities be provided to the community
- An ongoing community wellness group be set up and run by community members to identify areas of need, initiate projects and monitor progress

It should be noted that the above is not an exhaustive list of recommendations and activities to promote wellness should not be limited to these. Most were developed following a consideration of common themes and actions suggested by participants but further ideas could be drawn from individual responses as well as ongoing community consultations. Finally, the I-N=S+A=I equation which can now be expressed as 15-9=6+9=15, should also be acknowledged. This suggests that fifteen ideals, nine needs and six strengths were identified and that action in nine broad areas is needed for the improvement of community well-being. Nevertheless, interventions to enhance existing strengths as well as to address needs are consistent with a wellness perspective and proactive approach and should not be overlooked.

Validity

Discussing validity near the end of the final chapter has no relationship to the author's perception of the importance of validity. It is recognised that validity is an extremely important research requirement. Rather, discussing it here has benefits for the reader in that she or he may better assess in retrospect what has been done to ensure validity from start to finish.

Maxwell (1996) suggests that validity errors can occur at various stages or points of the research. Possible threats to the validity of this research were considered during the *design* of the study and attempts to minimize threats during the *data collection, analysis and conclusion drawing* stages of the research were also made. Validity in these four key areas is discussed below.

Research Design. The questionnaire/interview schedule was constructed in consultation with my supervisor and was piloted in a single interview prior to being used with a broader sample. This ensured that questions were understandable and generated meaningful discussion. While the sample size was small rather than large, the participants recruited somewhat reflected the real St Albans community in terms disadvantage and cultural diversity (the major cultural groups participated). That people of various ages were involved also improves the validity of findings. Youth aged less than 18 were not consulted in the present study but are currently the focus of action research in the second phase of the Community Wellness Project conducted by Julie Morsillo.

Care was taken not to impose our own ideas and values (bias) about well-being onto participants by having two general questions about well-being before introducing the concept of personal, relational and collective wellness and by introducing the levels in the model rather than the value items. It is important to note however, that the purpose of introducing the theory was not about seeking confirmation. Theory was used to raise participants' awareness of broader issues that could impact on well-being and to identify levels of need that could be addressed.

Data Collection. According to Maxwell (1996), valid 'description', or the accuracy and completeness of the data, can be usually be ensured by audio-taping [in this case interviews and focus group meetings] and by means of verbatim transcriptions

of the recordings after. This was done in the present study and notes written during these sessions were also kept and examined. Participants were encouraged to express their own views by informing them at the start that there was no right and wrong in their answers and that differences of opinion on the topic of well-being were expected. Attempts to interpret responses correctly were also made during the sessions by use of 'Rogerian' techniques such as 'summarising' and 'reflecting content and feelings' (Geldard, 1998). For example, following one participant's rather abstract discussion of well-being I asked: "So for you, wellbeing is living in an ideal world?" and he replied: "That's right".

Data Analysis. Qualitative research generates a great deal of data that must be reduced without undue loss of quality and meaning to ensure validity. Indeed the transcripts produced in this research consist of more than twice the number of words in this entire report. I have attempted to maintain the validity of quality and meaning by synthesising information rather than excluding it**.** The production of summary tables showing community members ideals and the suggestions for actions to improve well-being, are evidence of this. Attempts to minimise threats to validity were also undertaken during the production of common themes by using some very basic 'statistics' as suggested by Maxwell (1996). For example, several people had to have said or implied that good government was important for wellbeing for it to be classified as a theme.

Drawing Conclusions. Validity errors during this stage were avoided by acknowledging that the study was largely exploratory and by not generalising about diverse community members' ideals, needs and strengths. The study yielded a partial or tentative picture of wellness in the region but further ongoing work is required. Certain patterns emerged among the responses, but generalizations beyond the immediate samples, even towards the same cultural group, were not made because of sample sizes, research design and individual differences that might exist.

Implications and Limitations of the Research

Theory. Prilleltensky's community wellness model has not been employed in research before. Hence, this research was unique in terms of grounding the model. The combination of this theory with the concept of praxis and needs theory led to the development of a useful set of questions to explore the topic of community well-being. The framework generated a rich amount of information on the meaning of well-being from a multicultural perspective.

One of the limitations of the interview schedule was that it was more difficult to use with the Italian participants who did not have strong English language skills. Therefore, it is recommended that it be translated into community languages for use with people with English language difficulties. Another limitation in the present research was the sample size. Although the sample was sufficient to explore the topic and ground the model, one cannot determine the extent to which the findings of this research are characteristic of the broader region. Cultural differences could also not be adequately explored with a sample of this size. The community wellness cycle of praxis should be extended to a larger sample and to more cultural groups in the region in future research.

One should also be aware that there was also a considerable amount of overlap between some questions and responses. For example, it was not uncommon for issues that were raised in the first two questions to be raised again in other questions or for people to mention relational items when discussing collective issues. This can seem repetitive but should not be seen as a limitation. Rather, it indicates that people do not think in categories and that personal, relational and collective issues are indeed interrelated and synergistic. The overlap also applied to the analysis so that research questions could not be addressed by examining responses only to particular questions as anticipated.

It is interesting to note that the issues raised by community members share many parallels with other models and theories of well-being. Although it is not within the scope of this thesis to discuss the similarities and differences between these theories, it is important to note that almost all of the community themes were mentioned by 'various' authors reviewed in chapter two. For example, most of the elements of the 'good community' model (OHU, 2001), the 'wellness wheel' (Myers et al., 2000) and the VCOSS model were raised in the present research. The Deiner et al., domains:

satisfaction with education, employment, family, finances, friends, health, housing, partner, recreation, religion, self-esteem and transportation (1995) were also reflected in the present research. It is clear that there are many overlaps in these models. This implies that they may be tapping some universal aspects of well-being.

Most of the items in Prilleltensky's model were also supported in the present research. When one puts the common themes that came up in the discussions with community members alongside the community wellness model (see Table 15), it is clear that there are many similarities. However, two themes that emerged in the discussions with the community that are not present in the wellness model were spirituality and family. Also, while 'cultural harmony' is related to 'respect for diversity', the terms intra and inter cultural harmony specifically capture the diversity issues of importance to this community.

Table 15

Prilleltensky's Community Wellness Model and Community Perceptions of Well-being

Levels of Well-being	Community Wellness Model	Community Perceptions of Well-being
Personal	Sense of control over one's life, physical health, love, competence, optimism and self-esteem	Physical and Psychological Health. Positive Thoughts and Feelings (towards oneself and others). Spirituality.
Relational	Social support, affection, belonging, cohesion, collaboration, respect for one's diversity and democratic participation	Family. Friendship and Social Support. Intra and Inter Cultural Harmony. Community Cohesion and Participation. Human Rights.
Collective	Economic security, social justice, adequate health and social services, low crime (safety), adequate housing and social structures (e.g., educational, recreational and shopping facilities) and a clean environment	Safety. Employment. Education. Community Services, Resources and Information. Community Development. Good Government.

Another theme that emerged in the research with community members was 'good government'. This is related to the value: 'democratic participation' but points more specifically to the community's expectations for accountability from government. These findings should be taken into consideration in the further development of

wellness theory. Research with other communities should also be undertaken to ascertain the importance of these values for other communities.

Practice. The Community Wellness Cycle of Praxis and the findings that emerged in its use have implications for community practice and community improvement. This research has shown that people do indeed define well-being broadly. People have personal, relational and collective needs and values that should be taken into consideration in community practice. Community service providers who attend only to a clients' personal issues may be doing a dis-service if they ignore the broader collective needs of the person. Community workers should therefore engage in multiple levels of analysis to ensure the well-being of individuals and communities.

This study also makes a contribution to action research methodology and practice by presenting a clear cyclic model of inquiry and action. Many action research models are simply too abstract to serve as useful methodological guides. This sentiment is shared by Swepson (1998) who said that she found the literature on the practice of action research to be contradictory and that it left her confused about how to practice it.

This research will also assist the second stage of the community wellness project. Julie Morsillo has already utilised the questions developed in this study in her research with youths in the region and has commented on their usefulness. A copy of this thesis will also be given to the Good Shepherd organisation in anticipation that the findings might be useful in the development of programs, strategies or research designed to further assist the community.

The community wellness model and results of this research may be of use in various areas including local government, community development, social work and applied community psychology work. The 15 common ideals generated may be used to guide the assessment of individual and community well-being as well as a model for action. For example, in assessment we can ask questions such as: Is this individual or community physically and psychologically healthy? Does this individual or community have cultural harmony, safety and adequate education, employment, community services, resources and information? In action, we can design programs, services and structures that address the needs of the community and build on their strengths.

A cycle of praxis that engages community members to reflect on the meaning of well-being and on what is needed to achieve it is essential to the process of community improvement. In our efforts to improve community, we should give attention to action to address needs, action to maintain and enhance existing strengths and resources, and action to strive towards an ideal or vision of personal, relational and collective well-being.

References

Australian Bureau of Statistics. (2002). *Basic Community Profile: Brimbank (C) (LGA 21180)*. Drawn from the Australian Bureau of Statistics 2001 Census of Population and Housing. Melbourne: Commonwealth of Australia.

Bauman, Z. (1993). *Postmodern ethics*. Cambridge: Blackwell.

Bernstein, R.J. (1983). *Beyond objectivism and relativism: Science, hermeneutics and praxis*. Oxford: B. Blackwell.

Bottomore, T. (Ed.). (1983). *A Dictionary of Marxist Thought* (2nd ed.). Cambridge, Mass: Blackwell.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, MA: Harvard University Press.

Chambers, C. J. (1999). Situating psychological well-being: Exploring the cultural roots of its theory and research. *Journal of Counseling and Development*, 77 (2), 141-153.

Commonwealth of Australia. (1997). *Constitution of the World Health Organization. Australian Treaty Series: 1948, No. 7*. Canberra: Australian Government Publishing Service.

Cowen, E.L. & Work, W. (1988). Resilient children, psychological wellness, and primary prevention. *American Journal of Community Psychology*, 16 (4), 591-607.

Cowen, E.L. (1985). Person-centered approaches to primary prevention in mental health: Situation-focused and competence-enhancement. *American Journal of Community Psychology*, 3 (1), 31-48.

Cowen, E.L. (1991). In pursuit of wellness. *American Psychologist*, 46, 404-408.

Cowen, E.L. (1994). The enhancement of psychological wellness: Challenges and opportunities. *American Journal of Community Psychology*, 22, 149-179.

Cowen, E.L. (1996). The ontogenesis of primary prevention: Lengthy strides and stubbed toes. *American Journal of Community Psychology*, 24, 235-249.

Cowen, E.L. (2000). Community psychology and routes to psychological wellness. In J. Rappaport, & E. Seidman (Eds.). *Handbook of community psychology* (pp. 79-99). New York: Kluwer Academic/Plenum Publishers.

Curtis, S., Bryce, H. & Treloar, C. (1999). Action research: Changing the paradigm for health psychology researchers. In M. Murray and K. Chamberlain (Eds.), *Qualitative health psychology: Theories and methods*. (pp.202-217). London: Sage

Dalton, J.H., Elias, M.J. & Wandersman, A. (2001). *Community psychology: Linking individuals and communities*. Belmont, CA: Wadsworth/Thomson Learning.

Department of Immigration and Ethnic Affairs. (1986). *Immigrant women's issues*. Melbourne: Commonwealth of Australia.

Diener, E., Diener, M. & Diener, C. (1995). Factors predicting subjective well-being of nations. *Journal of Personality and Social Psychology*, 69, 851–864.

Diener, E., Suh, M., Smith, H. & Shao, L. (1995). National and cultural differences in reported subjective well-being: Why do they occur? *Social Indicators Research*, 31, 103–157.

Duffy, K.G. & Wong, F.W. (1996). *Community psychology*. Boston: Allyn and Bacon.

Freire, P. (1970). *Pedagogy of the Oppressed*. New York: The Seabury Press.

Fry, C. (2000). Culture, age, and subjective well-being. *Journal of Family Issues*, 21, (6), 751-777.

Geldard, D. (1998). *Basic personal counselling: A training manual for counsellors*, (3rd ed.). Sydney: Prentice Hall.

Gifford, R. (1997). *Environmental psychology: Principles and practice*, (2nd ed). Boston: Allyn and Bacon.

Grundy, S. and Kemmis, S. (1981). Educational Action Research in Australia: The state of the Art. In Kemmis, S. and McTaggert, R. (Eds.). (1988). *The Action Research Reader*, (3rd ed.), (pp.321-335). Geelong: Deakin University Press.

Hionides, H.T. (1987). *Collins Gem Dictionary: Greek-English, English-Greek.* London: Harper Collins Publishers.

Kagan, C., & Burton, M. (2001). *Critical community psychology praxis for the 21st Century*. Paper presented at the meeting of the British Psychological Society, Glasgow.

Kane, R. (1994). Through the moral maze. *American Behavioral Scientist*, 41, 578-597.

Kemmis, S. & McTaggart, R. (1988). *The action research reader*, (3rd ed.). Victoria: Deakin University.

Lee, D.Y., Park, S.H., Uhlemann, M.R. & Patsula, P. (1999). What makes you happy?: A comparison of self-reported criteria of happiness between two cultures. *Social Indicators Research*, 50, 351–362.

Levine, M. & Perkins, D.V. (1987). *Principles of community psychology*. New York: Oxford University Press.

Lu, L., Gilmour, R. & Shu-Fang, K. (2001). Cultural values and happiness: An East-West dialogue. *Journal of Social Psychology*, 141 (4). 477-494.

Masters, J. (1995). *The history of action research.* Action research electronic reader. Retrieved November 11, 2001 from World Wide Web: http://www2.fhs.usyd.edu.au/arow//reader/rmasters.htm

Maxwell, J.A. (1996). *Qualitative research design: An interactive approach*. Thousand Oaks: Sage Publications.

McKernan, J. (1991). *Curriculum Action Research. A Handbook of Methods and Resources for the Reflective Practitioner*. London: Kogan Page

Myers, J.E., Sweeney, T.J. & Witmer, J.M. (2000). The Wheel of Wellness Counseling for Wellness: A Holistic Model for Treatment Planning. *Journal of Counseling and Development*, 78 (3), 251-267.

O'Brien, R. (1998). *An Overview of the Methodological Approach of Action Research.* Retrieved October 27, 2001 from World Wide Web: http://www.web.net/~robrien/papers/arfinal.html

Ohio State University. (2001). *Seeking the Good Community,* (Ohio State University Fact Sheet: Community Development). Retrieved August 13, 2001 from World Wide Web: www.ohioline.ag.ohio.state.edu

Orford, J. (1993). *Community psychology: Theory and practice*. Chichester: John Wiley & Sons.

Prilleltensky, I. (1994). *The morals and politics of psychology: Psychological discourse and the status quo*. Albany: State University of New York Press.

Prilleltensky, I. (1997). Values, assumptions, and practices: Assessing the moral implications of psychological discourse and action. *American Psychologist*, 47, 517-535.

Prilleltensky, I. (2001a). *Personal and Collective Wellness: State of the Art* (power point presentation, hand-out). Delivered at the Launch of the Victoria University, Wellness Promotion Unit.

Prilleltensky, I. (2001b). Value-based praxis in community psychology: Moving towards social justice and social action. *American Journal of Community Psychology*, 29 (5), 747-777.

Prilleltensky, I. (2001c). *Doing Psychology Critically: Making a Difference in Diverse Settings* (power point presentation, hand-out). Delivered at the Seventh Trans-Tasman Conference in Community Psychology. "Showcasing Community Psychology – Making a Difference". Melbourne.

Prilleltensky, I. & Austin, S. (2001). Critical psychology for critical action. *International Journal of Critical Psychology*, 2, 39-60.

Prilleltensky, I. & Fox, D. (1997). Introducing critical psychology: Values, Assumptions, and the status quo. In Fox, D. and Prilleltensky, I. (Eds.). *Critical Psychology: An Introduction* (pp.3-20). London: Sage.

Prilleltensky, I. & Gonick, L. (1994). The discourse of oppression in the social sciences: Past, present, and future. In E. J. Trickett, R. J. Watts & D. Birman (Eds.). *Human diversity: Perspectives on people in context* (pp. 145-177). San Francisco: Jossey-Bass.

Prilleltensky, I. & Gonick, L. (1996). Polities change, oppression remains: On the psychology and politics of oppression. *Political Psychology*, 17, 127-147.

Prilleltensky, I. & Gridley, H. (2001). *Application for ARC small grants scheme: Community Wellness: A model for community assessment and change*. Unpublished grants application.

Prilleltensky, I. & Nelson, G. (1997). Community Psychology: Reclaiming social justice. In D. Fox and I. Prilleltensky (Eds.). (1997). *Critical Psychology: An Introduction* (pp. 166-184). London: Sage.

Prilleltensky, I. & Nelson, G. (2002). Doing psychology critically: making a difference in diverse settings. New York: Palgrave.

Prilleltensky, I., Nelson, G. & Peirson, L. (Eds.). (2001). *Promoting family wellness and preventing child maltreatment.* Toronto: University of Toronto Press.

Rappaport, J. (1977). *Community psychology: Values, research, and action*. New York: Holt, Rinehart and Winston.

Reardon, K. & Welsh, J. (1993). Participatory action research from the inside: Community development practice in East St. Louis. *American Sociologist,* 24 (1), 69-92.

Robson, C. (1993). *Real world research: A resource for social scientists and practitioner-researchers*. Oxford: Blackwell.

Roth, J. (1990). Needs and needs assessment process. *Evaluation Practice*, 11(2), 141-143.

Ryan, R. (1971). *Blaming the victim.* New York: Random House.

Ryan, L. & Dziurawiec, S. (2000). Materialism and its relationship to life satisfaction. *Social Indicators Research*, 55, 185-197.

Sarason, S.B. (1974). *The psychological sense of community: Prospects for a community psychology*. San Francisco: Jossey-Bass.

Schyns, P. (1998). Crossnational differences in happiness: Economic and cultural factors explored. *Social Indicators Research*, 43, 3–26.

Seng, J.S. (1998). Praxis as a Conceptual Framework for Participatory Research in Nursing. *Advances in Nursing Science*, 20 (1), 37-50.

Susman, G. (1983). Action research: a sociotechnical systems perspective. In G. Morgan (Ed.), *Beyond method* (pp.95-113). Beverly Hills, Ca.: Sage.

Sweeney, T.J., & Witmer, J.M. (1991). Beyond social interest: Striving toward optimum health and wellness. *Individual Psychology*, 47, 527-540.

Swepson, P. (1998). Separating the ideals of research from the methodology of research, either action research or science, can lead to better research. *Action research international* (on line journal). Retrieved February 13, 2002 from World Wide Web: http://www.scu.edu.au/schools/gcm/ar/ari/ari-papers.html

Taylor, C. (1992). *Multiculturalism and the "Politics of Recognition*". New Jersey: Princeton University Press.

Trewin, D. (2001). *Measuring Wellbeing: Frameworks for Australian Social Statistics*. Australian Bureau of Statistics.

Trickett, E. (1996). A future for community psychology: The contexts of diversity and the diversity of contexts. *American Journal of Community Psychology*, 24, 209-229.

Tseng, V., Chesir-Teran, D., Becker-Klein, R. & Chan, M.L., et al. (2002). Promotion of social change: A conceptual framework. *American Journal of Community Psychology*, 30 (3), 401-424.

Victorian Council of Social Services. (1999). *Australians Talk Citizenship: Report on National Focus Group Consultations Undertaken to Explore Concepts of Citizenship and Well-being, National Citizenship Project*. Melbourne: VCOSS and Swinburne University. Retrieved (Overview) October 20, 2001 from World Wide Web: http://www.vcoss.org.au/citizenship/overview.htm

Weil, M.O. (1996). Community building: Building community practice. *Social Work*, 41 (5), 481-500.

Westvale Community Centre (2001). *Westvale Online: History of Westvale*. Retrieved July 15, 2002 from World Wide Web: http://members.austarmetro.com.au/~westvale/westvale_history.htm

Wilson, H.S. & Kneisl, C.R. (1983). *Psychiatric nursing* (2nd ed.). Menlo Park, California: Addison-Wesley Pub. Co., Nursing Division.

Witmer, J.M. & Sweeney, T.J. (1992). A holistic model for wellness and prevention over the life span. *Journal of Counseling & Development*, 71, 140-148.

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