Wellness and Liberation in the Lives of Culturally Diverse Communities

(Phase-one of the Community Wellness Project)

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Abstract

The promotion of wellness and liberation in culturally diverse communities requires input from a wide range of community stakeholders including community members and community service providers/professionals. Collaboration with community members enables a grounded understanding of diverse community needs and facilitates the translation of values into action. In this paper we discuss two qualitative research projects, which employed a holistic model of wellness/well-being to explore perceptions of well-being among diverse community members and service providers/professionals from the St Albans region. The general aim of the studies was to gain a theoretical and practical understanding of well-being for this community. Findings from both projects support the utility of the model in generating a rich dialogue on factors that may lead us closer to community wellness and liberation.

KEY WORDS: Well being; Wellness; Praxis; Community Members; Professionals; Multicultural; Qualitative research

Introduction

Values, Action, Wellness and Liberation

This paper follows from a presentation delivered at the 9th Biennial Conference for [the Society for] Community Research and Action (SCRA) - Incorporating Diversity: Moving From Values to Action (June 2003, Las Vegas, New Mexico). Two qualitative research projects conducted with diverse community members and professionals in a poor multicultural community were the focus of the SCRA presentation[3]. We begin the present paper by addressing the conference themes: *Values, Action, Wellness and Liberation* before describing the methodology and discussing the findings and implications of the two research projects.

The terms *values and action* have become central themes for the field of community psychology since they appeared in Julian Rappaport's (1977) classic book entitled Community psychology: Values, research, and action and as implied by the name of the American Psychological Society Division for community psychology - the *Society for Community Research and Action*[4]. Values, research and action go hand in hand in that research on values can enable the latter. As stated by Tseng, Chesir-Teran, Becker-Klein, Chan, Duran, Roberts and Bardoliwalla (2002) a careful examination of the values of various stakeholders is essential to social change efforts, particularly when deciding what to promote and how to go about promotion. Therefore, values are guiding principles (Schwartz, 1994) or principles to guide action (Prilleltensky, 2003).

Even though some values and principles are regarded as universal, for example, justice and human rights (Kesler, 2000) values should be explored anew in each

[3] The presentation was delivered on behalf of the authors by Julie Morsillo (PhD candidate).
[4] The American Psychological Association lists 55 divisions. Community Psychology is known as Division 27 - Society for Community Research and Action: Division of Community Psychology (APA, 2004).

community, since as noted by Prilleltensky and Fox, “the particular configuration of values required for human welfare changes from society to society, group to group, and time to time” (1997, p. 9). The right for each community or culture to be judged by their own standards and to maintain its own values and style is strongly maintained by community psychology, which rejects the notion of a single standard (e.g., one cultural framework, set of norms, view of normality or wellness) (Rappaport, 1977). The role of shared values for community membership and a sense of belonging are also considered important in community psychology (Dunham, 1986; Fisher & Sonn, 2002).

Emory Cowen (1926-2000) should be accredited for introducing and developing the *wellness* concept in community psychology. Cowen viewed wellness as the “positive end of a hypothetical adjustment continuum - an ideal we should strive continually to approach” (1996, p.246). He viewed wellness as more than the absence of disease and was interested in wellness for all people (1994). 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 favor wellness and (4) promote empowering conditions and offer people justice, hope and opportunity; and (5) skills to effectively cope with stress. He further argued that wellness depended on the “synergistic presence” of the five strands (1994, p. 159). Cowen advocated for a preventative, proactive and transformative approach and was concerned about discovering the underlying dynamics of wellness. The terms wellness and well-being are used interchangeably in this paper to refer to a holistic state of physical, psychological and social well-being.

The influence of the *liberation* concept can be largely attributed to the work of Latin American ‘liberationists’ such as Paulo Freire (1921-1997) and Ignacio Martín-

Baró (1942-1989). Freire was a Brazilian educator who argued for a system of education (pedagogy) that could liberate oppressed people. In his book *Pedagogy of the oppressed* (1972) Freire outlined the nature of the pedagogy as one that "must be forged *with,* not *for* the oppressed" in order to help people regain their humanity from a dehumanising social reality. This pedagogy he claimed "makes oppression and its causes objects of reflection by the oppressed and, from that reflection, will come their necessary engagement in the struggle for liberation" (p. 30). Liberation emerges through dialogue and praxis: reflection and action on the world in order to transform it (Freire, 1972).

Martín-Baró was a Jesuit priest and social psychologist who questioned the basic assumptions underlying the psychology of his times and argued for a new praxis that is committed to the needs of the people. According to him:

> Only through such a praxis of commitment will we be able to get a new perspective on the people of our communities, with a view not only on what they positively are but of the negativity as well – of all they could be, but have been kept by historical conditions from becoming. The truth … will … not … be a simple reflection of data, … but of what *needs to done* (Martín-Baró, 1994, p. 23).

Values, action, wellness and liberation intersect in the present research, which explored community members' and professionals' perceptions of well being in order to facilitate action to promote wellness and liberation in the community. The two projects reported in this paper formed the first (exploratory) phase of a broader action research initiative known as the Community Wellness Project (Prilleltensky & Gridley, 2001)[5].

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[5] The Community Wellness Project was funded by the Australian Research Council and involved a research and community development partnership between Victoria University (VU), Wellness Promotion Unit and the community welfare organization called Good Shepherd Youth and Family Service (GSYFS). The two projects were the authors' theses for the Master of Applied (Community) Psychology degree at VU.

Theories Guiding the Studies

Community Wellness Model

Prilleltensky's (2001a) Community Wellness Model, needs theory as developed by Roth (1990) and an action research model known as the cycle of praxis (Prilleltensky, 2001b & c) informed the design of the phase one projects. The Community Wellness Model may be seen in Table 1. A major assumption associated with this 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" (Prilleltensky, 2001a, p. 2). The model can be described as a critical community psychology alternative to individualistic models of well-being, which tend to 'blame the person' (Ryan, 1971) and ignore the broader (relational and collective) forces, which impact on well-being.

Table 1

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

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 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 transportation facilities) and a clean environment

(Adapted from Prilleltensky, 2001a).

Praxis: From Values to Action

Praxis according to Martín-Baró is “an activity of transforming reality that will let us know not only about what is but also about what is not, and by which we may try to orient ourselves toward what ought to be (as translated by Aron, 1994, p. 29)”. In a progressive move towards praxis, Prilleltensky (2001b), proposed a cycle of praxis that 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.

The model also shares some methodological parallels with a needs assessment. According to Roth (1990) ‘need’ can be defined as the discrepancy between a target state and an actual state. As expressed by the following equation, X is the target state (e.g., values, ideals), A is the actual state and N is the need or discrepancy: $X - A = N$ (Roth, 1990).

A model that integrates Prilleltensky’s previous praxis diagram (2001c), with the concept of need and community wellness was developed by Totikidis (2003) and may be seen in Figure 2. The result of the integration is a cyclical model proposing that pragmatic plans of action (A) (what can be done?) to promote wellness and liberation must be based on research that explores a community’s ideals (I) (what should be?); needs (N) (what is?); and strengths (S) (actual state or what is?). The model has been referred to as Community Wellness Cycle of Praxis (Totikidis, 2003; Totikidis & Prilleltensky, in press).

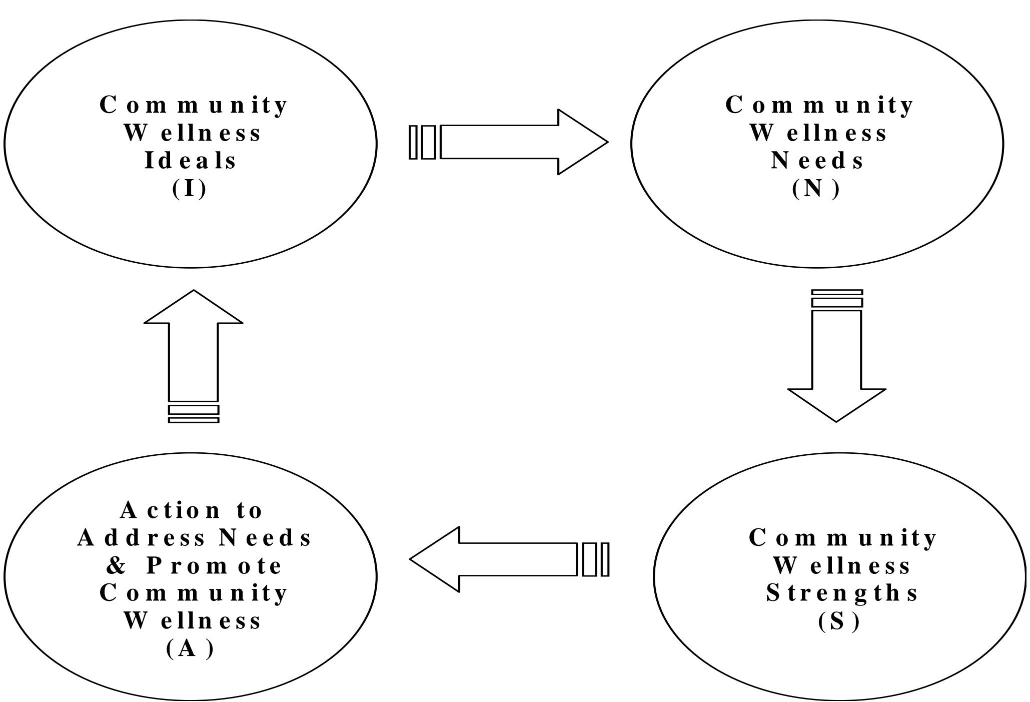

Figure 1. The Community Wellness Cycle of Praxis (Adapted from Prilleltensky, 2001a, b & c)

Aims and Research Questions

The aim of the two studies were to apply the Community Wellness Cycle of Praxis in qualitative research with diverse community members and service providers from the St Albans region in order to gain a theoretical and practical understanding of well-being for this community. The praxis framework guided the overall design of the research including the development of the following research questions and the interview/focus group schedule.

Specific research questions developed for the research with community members 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?

Specific research questions developed for the research with service providers were:

1. What are the community wellness ideals of service providers who work in the St Albans community? 2. What are service providers' perceptions of the needs and strengths of the St Albans community? 3. What actions can be undertaken to improve well-being in this community?

Method: Interviews and Focus Groups

Participants

St Albans is located in the Local Government Area of Brimbank, a region characterised by cultural and linguistic diversity as well as significant disadvantage. Over 70 languages are spoken in Brimbank with Australian born people making up the largest group in the region, followed by Vietnamese people, Maltese and then Italian born people (Richardson & Macaffer, 1999). The present research with community members involved a total of 31 people (17 women and 14 men) aged between 18 and 70 from these four main groups (Anglo, Vietnamese, Maltese and Italian) as well as two individual interviews involving a Maltese and Serbian woman to pilot the questions. Most of the participants for the community focus groups were recruited from local community centers, ethnic clubs and the St Albans shopping precinct with several referred by GSYFS staff.

The research with professionals consisted of two focus groups and nine individual interviews with a total of 27 participants, six men and 21 women.

Participants were recruited from local agencies through association with the research partner Good Shepherd Youth and Family Service. Participants ranged from over 18 to approximately 50 years in age and were from diverse cultural backgrounds. The cohort was made up of professionals working in Women's Health, Police and Family, Community Nursing, Counseling, Youth, Accommodation and Housing and Employment Support Services. All the participants had significant knowledge with respect to their own area of involvement and the issues faced by community members residing in the Western suburbs of Melbourne.

Materials

A semi-structured interview schedule consisting of four sections or themes and ten questions was used in the research. The schedule was designed for the research with community members and was then adapted for use with service providers. The version used with community members is shown in Table 2. With some overlap, section A, B, C & D correspond to the ideals, needs, strengths and actions of the praxis model and to the research questions posed earlier (see data analysis section).

The first two questions in section A were also employed in the interview and focus groups with professionals, thus the focus was on professionals' own definitions of well-being for the first two questions. Questions 3-8 (section B and C) inquired about professionals' perceptions of well-being in and for the St Albans community. The section D questions asked service providers to comment on what they thought community members could do to improve well-being (9) and what they (themselves) and other professionals could do for the community (10).

Table 2

Questions Employed in the Research with Community Members

Interview and Focus Group 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?
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?
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?
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?

Focus Group and Interview Procedures

The focus groups were held at GSYFS and each 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. Individual interviews were conducted in private counseling rooms at GSYFS with only the researcher and interviewee present.

The questions used during the focus groups with community members were presented both verbally (Totikidis) and visually using an overhead projector (Robertson) and brief notes of the responses were written on transparencies during the discussion for participants to see and reflect on. All the meetings were audiotaped for the purpose of producing verbatim transcriptions. A compensation of 20 dollars was given to each

community member at the end of the discussions. The focus groups with service providers were conducted in a similar way with questions presented verbally by the researcher (Robertson) and visually using an overhead projector (Totikidis). Service providers were not paid for their participation as they attended during working hours and were paid by their respective organisations. Questions were presented verbally in the interviews.

Care was taken not to impose our own ideas and values about well-being onto participants. This was achieved by asking two general questions about well-being (Section A) before introducing the concept of personal, relational and collective wellness, explaining that differences in opinion about well-being were acceptable, and by introducing the model by means of an uncomplicated colourful diagram. The diagram included the symbols used in Table 1 with the words personal, relational and collective, but not the value items within the model. As the researchers in this study we ascribed to the precepts of liberation psychology articulated by Freire by giving voice to others and understanding that it "is not our role to speak to the people about our own view of the world, nor to attempt to impose that view on them but rather to dialogue with the people about their view and ours" (1994, p. 77).

Data Analysis

Matrix analysis is a popular technique for analysing qualitative data as demonstrated by Miles and Huberman (1994). In the present work, a common conceptual analytical matrix was used to guide the analysis of data that emerged from the research with community members and professionals. An example of the matrix for community members appears in Table 3. This involved six analyses (2 interviews & 4 focus group). The relationship between the areas explored (top row) and interview/focus

group questions (second row) is also shown. The research with professionals involved 11 analyses (2 focus groups & 9 interviews; not shown in the table) and also involved attention to areas explored and interview/focus group questions.

Table 3

Conceptual Matrix Guiding the Data Analyses

Interview or Focus Group Analysis*	A. Well-being and Lack of Well-being		B. Personal, Relational and Collective Strengths			C. Personal, Relational and Collective Needs			D. Action by Community Members and Health and Community Service Workers, Governments, Researchers	
	1	2	3	4	5	6	7	8	9	10
1										
2										
3										
4										
5										
6										

The analyses involved reflecting on the research process, listening to the audiotaped responses and reading the transcripts, notes and transparencies. Whilst each researcher conducted the data analyses independently, some of the strategies used included highlighting, comparing, summarising and tabling responses, developing common themes and drawing out quotations to demonstrate themes and responses. Further strategies are discussed throughout the findings and discussion section.

Findings and Discussion

Community Members' Wellness Ideals, Strengths and Needs

Ideals. Participants' responses from all sections (A-D) and questions (1-10) of the interview schedule were examined to address the research question on community

wellness ideals. From this, concepts or factors that could be classified as ideals were entered into tables for each cultural group and the interviewees. These are too numerous to be presented here but are available elsewhere (see Totikidis, 2003; Totikidis & Prilleltensky, in press). Further thematic analyses of the tables, transcripts and other materials revealed 15 *common* wellness themes or ideals among the participants' responses as a whole. The themes are shown in Table 4, with three classified as personal, five as relational and seven as collective.

Table 4

Community Members' Personal, Relational and Collective Wellness Ideals

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

Of these 15 ideals, items one to six were considered to be areas of *strength* for this community while items seven to fifteen were areas of relative *need*. Community strengths and needs were determined by assessing whether responses related to each theme were positive and satisfied or negative and dissatisfied. For example, the following quotes (in Table 5) are obviously negative and dissatisfied and (together with other such comments by participants) point to the need for greater community cohesion and participation, improved safety measures, more responsive (good) government and work to promote respect for diversity (Inter cultural harmony) in the community.

Table 5

Selected Quotations Illustrating Community Wellness Needs

Examples of Community Need (negative/dissatisfied responses)	Theme
"Well like everyone talks about the transport [railway problems] in St. Albans [but] when it comes to blockade [protests] here, 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).	Community Cohesion and Participation
"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).	Safety
"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).	Good Government
"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).	Inter Cultural Harmony
"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 Services, Resources and Information
"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 centers … 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 nightclubs and certain places. But for the younger age group there is nothing" (Serbian woman).	Community Services, Resources and Information

Two types of cultural harmony were identified in the research with community members. One of these was inter-cultural harmony, which could be defined as harmony between cultures and which is related to tolerance and respect for cultural diversity. The other was intra-cultural harmony, which could be broadly defined as harmony in relation to one's own culture and could include positive cultural identity, adjustment

and self-acceptance. Although some people expressed negative attitudes towards other cultures, most participants displayed attitudes that were conducive to inter cultural harmony. A positive example of this theme is shown in Table 6 (first row). Further examples of community wellness strengths related to the themes of intra cultural harmony, spirituality and family are also shown in the table.

Table 6

Selected Quotations Illustrating Areas of Community Wellness Strengths

Examples of Community Strengths (positive/satisfied responses)	**Theme**
"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).	Inter 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).	Intra Cultural Harmony
"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).	Spirituality
"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 woman).	Family

Community Members' Suggestions for Actions to Improve Well-being in St Albans

A rich amount of information with respect to actions that could improve well-being in the community was generated in the research. As shown in Table 7, the responses consisted of suggestions on what community members felt they could do and on what they thought others (health and community service workers, governments, researchers) could do to improve well being.

Table 7

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

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 areas. 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.

A list of recommendations was developed after reflecting on participants' views regarding action and other issues identified in the research.

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

Professionals' Perceptions of Well Being

A summary of professionals' responses and selected quotes are presented in this section. Table 8 presents a summary of what professionals' thought were the positives and negatives of personal, relational and collective well-being for community members. Responses related to the first two general questions regarding well-being and the lack of well being have also been integrated into this table. Overall, participants' responses supported the view of Prilleltensky, (2001a) that well being is a holistic concept and that a balance in the personal relational and collective domains is crucial for overall wellness. As one participant so aptly explained:

> [*Well being is] "Feeling well mentally, physically, and emotionally... with a social side to that as well. It's the holistic approach, it's not just about dealing with some part of the person, it looking at all aspects."*

Table 8

Professionals Perceptions of Well Being and the Lack of Well Being in the Personal, Relational and Collective Domains

Well Being	Lack of Well Being
Personal	
Feeling valued, feeling balanced, self control, contentment, empowerment, control of own future, physical and psychological health, emotional health, ongoing sense of security, self esteem, confidence, self worth, physical and motivational energy, coping skills,	Stress-physical/emotional overwork, poor health, lack of work, negative emotions- anger frustration, mental health problems, powerlessness, lack of control, not being valued, lack of opportunity to develop creativity, lack of motivation, feeling like a third class citizen, isolation, fear, lack of skills.

Relational	
Social support-family, strong links with culture and family, harmony in the family, love, belonging-connectedness, tolerance of diversity in community, good work relationships, safety in community.	Negative relationships – general, family or work, generational cycle of disadvantage, family disruption, lack of sense of community, racism by potential employers, domestic violence, individualism, age discrimination in employment.
Collective	
Adequate support networks in health, education & employment, sense of belonging, schooling system supportive of cultural diversity and instrumental in connecting peers in wider community, dedicated service providers, educational opportunity, good networking and collaboration among the service providers, material aid available through services, fairness, social justice.	Lack of access to quality services, racial, economic & gender discrimination and labeling, negative relationships, economic hardship, inefficient public transport, menial work – impact on leisure, life and family, lack of affordable housing, homelessness, lack of sense of community, gentrification (reinforces underclass system), low income, adequate community education & information, inadequate public transport, huge job loss in recent years, work for the dole may have negative impact, basic needs not met, poverty among sole parents, inadequate doctors/dentists/community agencies, poverty trap.

Professionals' Perceptions of the Strengths of Community Members

Personal, Relational and Collective Strengths. It is interesting to note that when asked about what was good about the current state of wellness of community members at the personal level, professionals struggled to think in terms of the positive aspects of community members' wellness. This is reflected in the following two responses:

> "*I think sometimes it's just getting your mind frame around it (what is good or what are positive aspects for community members wellbeing) because we are always thinking in the negative…what is it that they want…because we don't take the time to think about what is positive."*
>
> "*They [community members] don't come into my orbit if they haven't got problems."*

This finding supports Prilleltensky's (1994) assertion that the nature of the health care professionals' work requires that they respond in a reactive manner and this

requires that there is a search for deficits as opposed to building on the positive assets, emphasizing strengths, health and wellness rather than deficits and limitations. However the nature of the health and welfare professionals' work entails that they do see people at their most vulnerable times and while participants, found it *"very difficult to talk in terms of what is good,"* they were able to identify positive aspects of the community members' when presented with the prompts. For example, one of the participants explained:

> *"My experience is that they [referring to Vietnamese people, in particular] experience themselves certainly as individuals but the collective is important…it's essential to their well being…the sense of belonging is important."*

In both the individual interviews and the focus group meetings health and welfare professionals indicated that there was a vulnerability among community members from the four ethnic groups and so community members could find security and protection by keeping close connections to their own cultural group. This relates to the theme of Intra-Cultural Harmony identified in the research with community members and was identified as conducive to personal, relational and collective wellness.

Professionals' Perceptions of the Needs of Community Members

*Personal Needs***.** The findings of this research suggest that there was sensitivity among professionals to the dominating psychosocial quality of life experienced by community members. When asked what was missing or lacking for community member's personal well-being participants indicated that social inclusion, material standard of living, feeling valued and respected is crucial to the quality of life for people they work with. Language barriers among community members were also identified as problematic which caused isolation and in turn had a powerful impact on the lifestyle

choices. Further issues raised as having a negative impact on personal well-being appear in the following quotes:

"[There is] a lack of access to quality services…the waiting period for quality services…economic hardship ... not being valued".

"Lack of respect…discrimination…lack of control in decision making …economic hardships."

"There is hostility in these groups [four main groups] and it's connected to acceptance and tolerance."

Relational Needs. Discussions around the negative aspects of community members' relationships with others included concerns over the identities imposed on others, about family breakdowns, early exiting from school and unemployment within this community. The discussions provoked a passionate response from participants in regards to labeling and victim blaming.

"Labeling…I think what happens is…when we don't know or understand we label…then we are able to make perceptions of what they are such as the long term unemployed…single mum's - they just keep having kids to get more money…the elderly well…they have done their time but … they can't participate or give back to society so we'll just make communities for them elsewhere…Young people that are not at school well, they're just bums or drug addicts …"

Collective Needs. The responses indicate that professionals believe that well-being is closely connected to community members' economic and social status at the collective level. The lack of access to quality services and affordable housing, low income, inadequate public transport, poverty among sole parents and difficulty satisfying basic material needs were seen as the negative factors influencing community wellness. Participants shared the ability to summarize their

perceptions of the lack of well-being to a compact essence. They described the aspects that contribute to the lack of well-being at the community level often in point form, indicating a familiarity with the local needs.

"The public transport system in Brimbank leaves a lot to be desired…this affects work opportunities."

"There are far few agencies in the west and doctors…there is so much trouble attracting doctors to the West (western suburbs of Melbourne) …there are fewer lawyers, fewer doctors there are fewer dentists there are fewer community agencies..."

"A lot of jobs have been lost as large organizations have been closed down particularly factory areas".

Professionals Perceptions on Actions or that could Improve Well-being in St Albans.

What can Professionals do to improve well being? Participants demonstrated an informed understanding of general needs and policy issues affecting the community that they worked in. Participants spoke of the need for critical interventions into social policy initiatives in order to provide equitable resource structures that take into consideration the "*regional issues and needs*". Health and welfare professionals viewed housing as an issue that highlighted the need in the community for equitable distribution of resources.

One of the reoccurring themes in the overall study and one of the major issues discussed at the collective level of intervention was that "*there is huge unemployment."* It was suggested that the government implement programs that help people to learn "*new job skills and find work.*" This would in effect liberate welfare recipients rather than keeping them "*dependent on the system.*" Participants explained that government responsibility also needed to be extended to increase funding to education, community

development and the health and welfare sector. Concerns were stressed over inadequate levels of funding to respond to the needs of clients. The length of time required to wait for an initial appointment was cited as an indication of the need in this area, as one participant explained: "*I think one of the things is economic resources which take time and effort to access…we have long waiting lists.*"

What can community members do to improve well being? The overall response to this question suggest that health and welfare workers perceive their client base to be, to some extent, powerless in bringing about change. It seemed highly implausible to health and welfare workers that there was any real lifestyle choices to be made without social changes in employment and educational opportunities. The existing literature tends to favour the notion that feelings of control can enhance or prevent the degree of decision making power the person has to shape their own life and take control of their health (Rappaport, 1987). This was a reoccurring theme among participants. For example one of the participants explained:

> *"It's the ability to actually make choices and that doesn't mean that people can't make choices but there very limited choices …… unless people have a sense of control of their lives and they're basically pro-active, in terms of seeking support structures…and knowing how to access what they need in order to get what they want. Then it makes it very hard to get out of the spiral."*

The responses from participants in this study support the assertion that health and well-being are related to economic status and that change could only occur through action at the collective level. As said:

> "*Better health outcomes and lack of disease are absolutely related to the economy…to tell the individual to rise above that to go out and find a way out [of their problems]…it's not realistic…it adds to a sense of hopelessness*".

The participants offered ideas for tackling the negative aspects that impact on community member's wellness and this included involvement in action and education as a tool of empowerment. Previous research also suggests that one path to promoting empowerment and change in the client, is to incorporate education about power into everyday practice so that people gain awareness of oppressive forces in their lives and of their own ability to overcome injustice (Prilleltensky, 2000).

Conclusions

This research employed the Community Wellness Cycle of Praxis to explore the views of community members and professionals in the multicultural suburb of St Albans. The praxis model encourages participants to reflect on personal, relational and collective aspects of well-being in order to identify the ideals, strengths and needs of a community that can guide future action to improve well-being.

Our assessment of this model was that it was useful in generating a rich dialogue among participants that was reflective of their "*situation* in the world" (Freire, 1993, p. 77). Thus the model could be employed equally well with different populations to assess their own special needs and views of 'their' world and most importantly to generate concrete ideas for actions that could improve well being in the community. Even so, people cannot discuss issues that they do not know about so broader samples and other strategies to assess community needs (e.g., surveys and analysis of social indicators) are warranted for a more comprehensive account.

It is interesting to note that service providers' responses showed a greater focus on collective needs for wellness. The comparisons made between the personal, relational, and collective levels indicate that professional's perceptions of the positive

aspects of well being for this community are to be found in the relational domain and that the negative aspects of wellness are closely connected to their economic and social status at the collective level. There is also evidence from the results that health and welfare workers consider community resources to be scarce. In so far as wellness is a product of one’s social standing in life, there is a continuation of concerning among health and welfare workers trends in the shortages of accessible and equitable resources across the community. This was largely supported in the research with community members, although unlike the research with professionals, the community research revealed a more pressing need for improved community cohesion, participation and cultural relationships in addition to collective concerns regarding resources and infrastructure.

While the professionals’ struggled to provide proposals for the ways in which community members could help themselves they provided a prolific amount of information on the ways in which society at large could improve conditions for the community. It is clear from the findings that professionals understand that the factors that determine wellness are not always in the control of the person and that remedial efforts aimed at the personal level of wellness continue to make little progress. According to professional’s perceptions for this community in Melbourne’s West, what is clearly required for a balance in the community’s overall wellness are fundamental changes and provision of resources at the collective level.

Professionals believed that wellness is also determined by choices that are made; being able to have control over choice of life’s circumstances and by ensuring that the society we live in creates conditions that allow for the attainment of wellness. There is a need in the community for advocacy in regard to these issues and the findings suggest

that participants understand that there is a need for channels to be opened between the health sector and the broader social political and economic structures at the collective level. In wellness promotion we have to be careful in defining what is needed and by whom, when and where. It is suggested that future research be decisive in taking into consideration the views of community members and that they take part in defining what wellness means.

Finally it is suggested that wellness promotion works through concrete and effective community dialogue in setting priorities, making decisions, planning strategies and implementing them. Through such communication, disadvantaged groups can get the recognition and support they need to encourage resilience and a positive self-identity. These are the imperatives that can create different paths towards wellness and at the center of this process is the empowerment of communities, their ownership and control of their own affairs and destiny.

The responses of community members and professionals working in the health and welfare sectors of the area of Brimbank provide some on-the-ground support of a model that juxtaposes personal, relational and collective needs as equally essential to the attainment of wellness. However it was acknowledged that professionals' responses were coloured by the nature of own crisis oriented work. Changing the "mindset" of professionals away from traditional preoccupations with individual deficits and towards solutions that engage personal, relational and collective strengths is likely to be a long term undertaking. A wellness model that is relatively simple to describe and understand, as utilized in this study, offers a tool for developing balanced approaches and gauging progress in the balanced promotion of wellness at all three levels.

This research could prove valuable for future development of theory and practical interventions, assisting and informing the further community development objectives of the larger Community Wellness Project. The research is an important step in understanding how psychological wellness is experienced and how it can be promoted in different life stages and settings. The initial phase of this research has demonstrated that both community members and professionals have a valuable role in the promotion of wellness. The information gathered from these stakeholders in the community, needs to be added to the theorization of a psychology of wellness. We have attempted to understand the common reflection of and for the community and in turn facilitate a vision for action based on the needs and aspirations of the community.

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