

# The Australian Community Psychologist

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College of Community Psychologists



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## General Information

The Australian Community Psychologist is the Official Journal of the College of Community Psychologists of the Australian Psychological Society

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## Editorial

Lauren Breen

*Edith Cowan University*

The Australian Community Psychologist is auspiced by the Australian Psychological Society, and I am required to write an annual report on the journal. I was very proud to note in my report that previous authors and their work published in ACP has been discussed in the media. For instance, Triple J radio interviewed an author about her project with young fly-in/fly-out workers while another author was interviewed on an SBS television program about gaming research. Additionally, ACP is accessed by local and international readers, receives manuscripts from local and international contributors, has earned an ERA ranking from the Australian Research Council, and is indexed in the PANDORA database.

This issue of ACP presents a special section devoted to the Trans-Tasman Community Psychology conference, which is a biennial conference shared between Australia and Aotearoa/New Zealand and is the premier community psychology conference in the southern hemisphere. Previous conferences have been staged in Pakatoa (1989), Maralinga (1990), Rotorua (1992), Yarrabah (1993), Toodyay (1996), Hamilton (1998), Melbourne (2001), Perth (2002), Tauranga (2004), and Sydney (2006) (Gridley & Breen, 2007).

The 11<sup>th</sup> conference was held in Fremantle from Wednesday 15<sup>th</sup> to Friday 17<sup>th</sup> July 2009 and was themed "Exploring Boundaries, Expanding Frontiers". The sub-themes centred on current and emerging discussions and debate within community psychology research and practice. The six keynote speakers were:

- Associate Professor Darrin Hodgetts, Department of Psychology, University of Waikato, Aotearoa/New Zealand;
- Professor Beth Shinn, Peabody College, Vanderbilt University, United States of America;
- Dr Paul Duckett, Department of Psychology and Social Change, Manchester Metropolitan University, United Kingdom;

- Professor Colleen Hayward, Kurongkurl Katitjin, Edith Cowan University, Australia;
- Mr Darren Garvey, Centre for Aboriginal Studies, Curtin University of Technology, Australia; and
- Professor Margaret Sims, School of Education, University of New England, Australia

After the conference, presenters were invited to submit manuscripts for publication in *The Australian Community Psychologist*, and four of these submissions are included in this issue. Darren Garvey provides an updated version of the stimulating and thought-provoking keynote address he presented to the conference delegates. He reflects on how to work better with Indigenous people, which, as Darren explains, is still often met with resistance and ambivalence but need not be. Vicky Totikidis presents some of her community-based interventions for health promotion and disease prevention. She demonstrates that the nominal group technique is a useful tool in assisting community members to develop ideas to effect positive health and wellbeing. Julie Ann Pooley and Lynne Cohen describe several studies of resilience to offer a contextual definition of the term, and in doing so, make an important contribution to the resilience literature. Ken Robinson and Glen Scott-Pillow present their evaluation of the 11<sup>th</sup> Trans-Tasman Community Psychology Conference. Their analysis of the conference's successes and areas for improvement will be useful to organisers of forthcoming Trans-Tasman conferences.

Following these articles drawn from the conference is one general paper. Jade Dyer, Leesa Costello, and Paul Martin present their findings on the use of an Internet support group for cardiac patients. The paper is important given the ever-increasing utility of technology and is useful in relation to our understanding of online communities. Next, book reviews are

provided by Alison Garton, Katie Thomas, Carol Tutchener, and Lyn O'Grady. These are followed by Rhona Weinstein's obituary for Seymour Sarason, a key and influential figure in the field of community psychology.

Finally, an upcoming issue of ACP in 2011 will be themed, 'Resilience: Diverse perspectives and contexts in working with resilience' produced by an editorial team led by Lynne Cohen. Manuscripts may be of a theoretical or empirical focus and may be drawn from research projects or reflections on practice issues. The deadline for submissions is 31 January 2011 and the issue will be published in May 2011. Submissions can be sent to, and further information requested from, Catherine Ferguson at [c.ferguson@ecu.edu.au](mailto:c.ferguson@ecu.edu.au).

### Reference

Gridley, H., & Breen, L. (2007). So far and yet so near? Community psychology in Australia. In S. M. Reich, M. Riemer, I. Prilleltensky, & M. Montero (Eds.), *International community psychology: History and theories* (pp. 119-139). New York: Springer.

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## **‘Ready, Steady... Practice!’: How Working Better with Indigenous Australian People can Take as Little as Three Minutes of Your Time**

Darren Garvey  
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*For fans of a certain afternoon cooking show, the title of this article may bring to mind the frantic preparation of apparently delectable meals relying on a restricted range of ingredients within a restrictive time frame. The notion that good things may be achieved in a short period is applied in this article which proposes that it is the choices made within the minutes of our psychological practice that contribute and accumulate to better working relationships with Indigenous Australian peoples. I discuss the impact that an expectation of criticism may have on health professionals and students when confronting the overwhelming prospect of working with Indigenous Australian peoples. The idea that a great deal of effort is required to bring about what only ever seem to be small (if any) improvements in the wellbeing of Indigenous Australians is challenged by suggesting that it is the enactment of small, repeated efforts which have the potential to produce important and sustainable relationships, and a platform for ongoing, collaborative ventures. To begin, readers are encouraged to endure a number of confronting ‘truths’ about the psychological profession and its members. Although the statements are delivered here to a community psychology audience, their relevance for the profession is arguably broader than that, spanning academic and applied domains, as well as the concerns of students. These provide a challenging precursor to the development of the idea of ‘three minutes’, including several activities aimed at setting readers on a path to making every minute count.*

Psychologists and others who would deem themselves part of the so-called ‘helping professions’, actually contribute to the ongoing and insidious oppression and marginalisation of Indigenous Australian people. You see, you and your kind, for all your best intentions, can never be more than another piece of the machinery that has been imported to subjugate and disempower. How else can you explain the incessant gnawing of something ‘not quite right’ about what you do with Indigenous people? It endures despite your best efforts to soothe it with the balm of cultural appropriateness and a fumbling, self-conscious sensitivity. Worse still when you use Indigenous people as pawns towards your own ends, co-opting the misery and misfortune of others to either satisfy and purge your own demons of unearned privilege, or to add culturally derived permission to pursue your own agenda.

Your legacy is more searing than any

piece of shot or cumbersome iron shackle, and more lethal than any poison or germ used to spoil a water hole or infect a warming blanket. You have bred mistrust in the guise of benevolence through your social experimentation and your inheritance is a social landscape bereft of trust in you and your so-called expertise. Even those among you who express the desire to destabilise positivistic and impersonal psychology merely succeed in creating edifices that reflect fundamentally the same self-serving and selfish needs of the profession. In the end you never really stray too far from that which you deride and merely hoist self-effacing pot-shots at the hand that feeds you. How can you do otherwise when professional credibility, academic acknowledgement and peer recognition act as all too tempting carrots to draw you away from developing truly genuine relationships. Just look at the language you use. Who does it appeal to? Does it change much from the

scholarship required to be 'published lest you perish', and the vocabulary you use to co-opt and confound your subjects? Are uncertainties about the validity of clinical diagnoses or counselling models regarded as an artefact of a professional speciality, or a deficit of Indigenous peoples' ability to conform to them? Ironic too don't you think that the jargon used to reflect 'community', merely serves to erect linguistic and technical barriers that cement the divide between you and them?

And so you meet with your intentions to, "Cross Borders, Remove Barriers, Drive Change and Challenge Assumptions" which, despite the suggestion of revolution, merely reinstates the status quo by providing a professionally soothing mantra to obscure more sinister desires bent on the containment and destruction of Indigenous identity. Unfortunately, forums such as this only seem to provide the opportunity for you to gather with your collaborators so you might feel virtuous and righteous and impervious to critique, while recycling the distorted title of 'helping professional' in ways that re-imbue it with power and prominence amongst your insular and self-interested selves.

### **Introduction: Take two**

Perhaps a tirade such as this characterises the anxious thoughts of many budding, and not so budding psychologists wanting to, or required to work with Indigenous Australian people? I suspect that these words and the criticisms they embody are those that many people expect to hear from their Indigenous Australian clients, or anticipate them silently harbouring. From the outset let me say that not every Indigenous person holds these hypercritical views of community psychology or community psychologists. I can also say with a fair degree of certainty that not every Indigenous person knows what psychology, community or otherwise, is, let alone possesses an opinion of the skills or personalities of its members. The views contained in the introduction are also not necessarily those of this author; however they are distilled from the author's experience from over two decades work in community, clinical and

classroom settings with Indigenous and non-Indigenous Australian peoples. They are also filtered through the author's identity as an Indigenous Australian person and psychologist, a particularly hybrid position that permits an insight as both target for, and provider of, psychological services for Indigenous Australians.

The 'truths' outlined above are included deliberately here primarily as a provocative device to prompt reflection, and in particular, to gain an insight as to whether your reaction tended towards the accommodating, retaliatory or dismissive? Reviewing the introduction, did you find yourself responding defensively against what the remarks were saying about you or your chosen work, or offensively because they didn't go far enough? Did being homogenised ("you and your kind") elicit a reaction to being stereotyped, or were you thinking, "oh no, here we go again, why does he have to bring that stuff up here? Can't they (Indigenous peoples) just get over it?" Or, "I didn't pay my conference fee to get told that I'm a bad psychologist, let alone a bad person!" If so, these may well have primed you for how you view the rest of this article, if indeed you choose to read on.

### **A little history**

Concerns about a critical reception are at least as old as those told during the fledgling "Psychology and Indigenous People" interest group meetings convened at the Centre for Aboriginal Studies at Curtin University, some fifteen or so years ago. At the time, this forum provided a space for discussion and catharsis for psychologists working with Indigenous Australian people as clinicians and researchers, and also for students interested in the field. Interest in the social and emotional wellbeing of Indigenous people was receiving unprecedented stimulus, prompted by inquiries into the incarceration (Royal Commission Into Aboriginal Deaths in Custody, 1991), removal (Human Rights and Equal Opportunity Commission, 1997) and mental health (Human Rights and Equal Opportunity Commission,

1993) of Indigenous Australian peoples. Psychology was in many ways implicated in this milieu as a means by which to understand and ameliorate the attendant psychological repercussions of these not-so historical traumas. However, while such reports highlighted the dearth of research and culturally appropriate resources, a corollary of these revelations was a critical backlash aimed at services and service personnel who had, in the eyes of many Indigenous and non-Indigenous people, failed to demonstrate a satisfactory duty of care (e.g., Swan & Raphael, 1995). This has placed professions such as psychology, and professionals such as psychologists, in the catch-22 situation of being implicated as both the cause and solution to problems relating to Indigenous social and emotional wellbeing. Negotiating this position as 'enemy and ally' remains a tense proposition.

This has seen many helping professions engaged in a process of critical reflection on their involvement with or ambivalence towards Indigenous Australians. While the ensuing years have witnessed action by psychology to address both ethical and practical concerns (Gridley, Davidson, Dudgeon, Pickett, & Sanson, 2000), the critical residue of this period also lingers as anxiety and hesitance for many students and practitioners with regards to what constitutes good service, and good service provider behaviour. It seems that for all the good promised by the critical stocktake of psychological endeavours with Indigenous Australian peoples, an attendant void has developed whereby the certainty provided by what had been regarded as adequate professional behaviour, has since been destabilised by its rejection as inappropriate. Understandably, questions of how to work, research and relate better with Indigenous people remain at the forefront of student and practitioner conversations, just as they were in spaces such as that provided by the Centre for Aboriginal Studies nearly two decades ago.

### **A case in point**

Today these concerns are retold by a new generation of students, graduates, researchers and clinical and community practitioners, cognisant to varying degrees of the reconciliatory, post-apology context in which their actions are located and judged. A recent example concerned a Masters student as he prepared to embark on his fledgling career. Keen to work with Indigenous Australian people, his counselling competence appeared above reproach. Yet his concern for his lack of cultural competence presented as a factor likely to undermine the development of his psychological practice, due to it having already undermined his confidence. Our meeting began with the familiar request for facts about Indigenous people and the checking of what he believed to be facts about Indigenous people – “are we this?”, “are we that?”, “is eye contact acceptable?”, “what kinds of approaches are ok?”, and so on. His questions were also underlined by a concurrent concern – given that there is so much to learn, how can one ever hope to be ready to practice without having learned it all? In response I provided my usual frustrating, albeit honest answers of either, “I’m not sure” or “it depends”, both of which act as a means of reducing the pressure that I, and perhaps other Indigenous people feel when placed in the position of being the experts on absolutely everything Indigenous. They also provide an opportunity to pause in order to consider how best to respond.

In this instance I suggested we examine the questions he was asking, discovering that they were as much aimed at minimising anxiety about the anticipated misgivings he felt Indigenous people would undoubtedly and automatically have about him and his work, as they were about raising his awareness and understanding of Indigenous Australian peoples. Although not initially expressed, his questions were concerned with allaying fears of anticipated critique (like those in the opening tirade) as much as they were about gaining clinically useful information geared towards

enhancing his professional competence.

### **The best defence**

Anticipated critique has been discussed previously as a factor in barriers to working with Indigenous Australian people. Williams (2000) describes the role persecutory guilt has in explaining students' ambivalence towards working with Indigenous people. A pre-emptive anticipation of rejection acts as a reason for avoiding engagement in the first place, or at least fosters the construction of relationships that are tentative and cautious. Williams notes that students may avoid expressing opinions that could be construed as insensitive to the plight of Indigenous people in order to appear inoffensive and as not participating in any ongoing program of oppression or racism. In my experience, students (and clinicians and researchers) often desire to do the right thing for fear of doing the wrong thing – a fear that at its extreme can invoke a paralysis of sorts, derived from knowing that while culturally competent service is mandated, grappling with the emotive and cognitive constraints triggered by what they believe this requirement entails, can be overwhelming.

Radermacher (2007) provided a student's perspective of approaching Indigenous studies, describing how a variety of strategies are employed in order to rationalise non-participation and non-engagement. Interestingly, she notes that this course of action appears more prevalent for students born in Australia. Resistance and avoidance makes discussion of disengaging positions difficult and often impervious to examination. However Radermacher's description of her own journey to greater awareness demonstrates that pitfalls and discomfort, while likely, are traversable, but this also requires a willingness to confront uncertainty and court offensiveness.

This point has implications for facilitators of tertiary courses to ensure a degree of safety for those in the midst of such self-disclosure, and the skill to integrate what is said into an ongoing narrative of cultural competence development (e.g., Gerrett-Maggee, 2007). Consideration is

also required by lecturers who in their efforts to confront entrenched positions, merely succeed in reinforcing the status quo by an over-zealous appeal for change. In my experience, movement towards reflection on these matters is rarely achieved by just telling someone to do so, and can require a lecturer to demonstrate vulnerability and courage when examining their own position, as well as that of their students.

While the best defence against an anticipated charge of racism, insensitivity or ignorance may be to deploy pre-emptive arguments to the contrary, or to avoid the risk of imperfect engagement in the first place, the prospect of developing genuine and honest relationships remains unlikely. I suspect the Masters student described earlier was seeking a course that would sustain, validate and legitimise him to work with Indigenous Australians by affirming the potential for success through incremental effort. His investment in the time to speak openly and participate imperfectly at our meeting exemplified what I have termed, "fearless conversation" (Garvey, 2007), and was, in my opinion, a good indication of his willingness to engage in a generative and cumulative process of competence development. The positioning of the fledgling practitioner as incomplete and imperfect, while humbling to adopt, is far less demanding and far more realistic than the (often self-imposed) expectation to be fully-formed and faultless. This position does not need to devalue or deny the skills or competence that the person may already possess. It suggests instead that a negotiation as to their relevance, meaning and value for Indigenous peoples needs to occur, as do similar conversations concerning the role and place of the psychologist.

### **Explaining the title: 'Ready, Steady ... Practice!'**

So what does a reference to the cooking show, "Ready, Steady, Cook!" have to do with this endeavour? The frivolity suggested by the reference is meant as more than an attempt to provide a quirky title, and certainly not an

indication of the levity with which I regard the pursuit of working better with Indigenous Australian peoples. I do, however, admit to being a fan of the cooking show genre as perhaps are some of you? I even considered different titles; however, 'Master Psychologist', 'My Psychology Practice Rules' or even 'Iron Psychologist' seemed a little grandiose. But there is a serious reason for this pop cultural reference. For those unfamiliar with the show, it is a contest between two chefs assisted by audience members, using a limited number of ingredients in a short period of time. The title 'Ready steady...practice!' then is part invitation and part enticement to consider what might be achievable in a matter of minutes.

Speaking of pop references, can you identify a common feature of the following songs?

1. Bad, bad, Leroy Brown – Jim Croce (1973)
2. Honky tonk women – The Rolling Stones (1969)
3. Can't help falling in love – Elvis Presley (1962)
4. The fool on the hill – The Beatles (1967)
5. Goldfinger – Shirley Bassey (1964)
6. Build me up buttercup – The Foundations (1968)
7. Your love keeps lifting me higher – Jackie Wilson and the Funk Brothers (1967)
8. Desire – U2 (1988)
9. We are the champions – Queen (1977)
10. Daydream believer – The Monkees (1967)

A common feature is that the original versions of these songs are all less than or equal to three minutes in duration. If you were able to recognise the titles and something of their melody, it could be said that it doesn't take long for a lyric or tune to infiltrate our memory such that we find ourselves humming, tapping or singing along unexpectedly, sometimes to our own or other peoples' annoyance.

Brief utterances taking much less time than this can also make an impact in profound and enduring ways. If you were to reflect for a moment on important events from your life, I suspect they include succinct yet meaningful words or phrases. Examples of these words, received and delivered, might include:

- "Will you marry me?"
- "I do"
- "It's a boy!"
- "It's a girl!"
- "I hate you!"
- "I love you"
- "We regret to inform you..."
- "No"
- "Yes"
- "I understand"

While it can take but a matter of moments and a handful of words to experience something life-changing, sometimes words aren't even required. For example, a second son recently joined our family, and I suggest that all it took was the sound of that first inhalation of breath, the squawk of new life and the cry indicative of a healthy set of lungs to deliver an unfathomable, wordless impact. Granted, I now concede that the very same cry could stand to have its volume and frequency reduced between midnight and 6am.

Sometimes there are very simple words that are brief in their duration yet monumental in impact. While it takes about 20 seconds to read the following statement, its meaning still resonates for many:

*For the pain, suffering and hurt of these stolen generations, their descendants and for their families left behind, we say sorry. To the mothers and the fathers, the brothers and the sisters, for the breaking up of families and communities, we say sorry. And for the indignity and degradation thus inflicted on a proud people and a proud culture, we say sorry.*  
(Kevin Rudd PM, February 13, 2008).

While such examples suggest that an impact can be made in a matter of minutes, proposals of marriage or expressions of affection, refusal or agreement, will usually have had some degree of forethought, and consideration for their consequences. Similarly, commentators and community people alike,

while acknowledging the words of our former Prime Minister, remain hesitant in handing out their unmitigated praise and thanks, preferring to wait a while in order to see what happens as a result of this landmark apology. Still, there can be little doubt as to the immediate and longer term impact that such brief events can deliver, and harnessing this potential in the context of our work with Indigenous Australian people is worth considering.

### **The deadly package**

While the preceding examples have attempted to highlight this potential, the following case study provides an opportunity to propose junctures at which a few moments consideration may have been prudent.

*A colleague recounted the story of a visit to a remote Aboriginal community. His scheduled work done for the day, he was invited by the local school principal to hop in the back of the truck and take a drive out to pick up some materials for the students upcoming dance tour. Several of the students had come along for the ride as well and so off they all went, bumping up and down on the corrugated dirt road that led out of town. After a while, the truck stopped. My colleague didn't know where they were, but the children seemed to as they ran off to explore. Looking around, apart from a clump of thick vegetation to one side of the track, the rest of the place seemed devoid of life. The heat radiating from the ground created that shimmering effect in the distance – like water where there's no water. There was a faint odour of smoke in the air which seemed odd given the lack of things to burn. My colleague continued to survey the place, desolate, hot and getting hotter. All of a sudden, his eyes were drawn to a particular spot on*

*the horizon. It was as if there something, or someone emerging from the shimmering pool. One figure...no two were now getting clearer and closer. Thin figures, very dark figures. One slightly taller than the other with the taller one carrying what looked like a spear! The lack of concern from the principal caused my colleague to wonder whether he was in fact imagining this? A hallucination? A trick of the light?*

*In fact, the approaching figures were real people, a husband and wife who had been looking for food while the materials were being prepared in an open fire that had since burned down to coals and was smouldering nearby. Tied to the spear were two fish. It seemed that there was real water close by as well if you knew where to look. They all walked over to the coals and in the middle of the pit was what looked a package of singed and smouldering bark protecting something within. Some of the substance – what looked like a powdery, clay-like material spilled out where the leaves had burned through. The principal asked on the progress of the preparation and the tall man seemed satisfied with the finished product. He bent down and carefully removed the parcel, setting it to one side, allowing it to cool. The principal continued to talk with the couple some more, probably about the upcoming dance tour. It was at this point that my colleague made a confession about his conduct. He had become focussed on the package and what it contained. Not knowing the answer to this he*

*found his curiosity rising.*

*Accompanying his curiosity was the chance to feel and experience something 'special', something authentic, something cultural. So while the others spoke some more, my colleague moved closer to the package, bent down and ever so gently, picked at a piece of the material that had dislodged itself. 'Wow,' my colleague thought. Such was his attention on the clay that he had failed to notice the tall, slender Aboriginal man watching him watching the package. He had seen my colleague's movement and was himself now moving towards the coals. "Uh-oh!", thought my colleague as the man approached him, spear still in hand. "What have I done?" He looked towards the ground but felt the man's silent stare piercing him. "Better that than the end of that spear", he thought. The man then bent down to the package and observed the exact place that my colleague had touched. He extended his wiry hand and with a flick of the forefinger, removed the piece of clay that my colleague had touched. Not a word was said.*

*The bumpy ride back to town was a little quieter as my colleague reflected on the experience. He suspected that his actions had resulted in his contaminating that small piece of material and therefore it had to be removed. Two lessons emerged: 1. Be careful where you stick your fingers. 2. Just because you have fingers, it doesn't mean you can put them where you like, whenever you like. (Garvey, 2007, pp. 46-47)*

I have used this story previously as a self-disclosure because I am the main character, the so-called 'colleague', revealing my own imperfection and sources of lessons learned in relation to many of the professional matters that I discuss with students, practitioners and researchers. I include it here for the purposes of demonstrating that a minute or two spent considering the appropriateness and consequences of my personal desire in this context could have led to a very different and potentially less life threatening situation. In retrospect, I could have waited a minute or two to consider what I should do with my rising sense of curiosity. I could have asked permission, or at least asked someone about what was permissible and not permitted in this context, with the response guiding what would have been culturally safe behaviour on my part. I could have considered that the impact of a seemingly small gesture might have larger ramifications or mean something other than misplaced curiosity. So many options in that moment apart from the one that I chose, all of which in retrospect would have taken much less than the three minutes argued for here. In fact, the content of any three minutes need not be filled with words or questions at all, instead used as an opportunity to consider what one would like to do and the potential ramifications – an opportunity to pause for thought. I suspect that had I been required to visit that community again, I would have been considered *persona non grata* for some time – at least until I had made amends. I also suspect that the process of relationship re-building would have taken much longer than three minutes. Perhaps in your reading of the story you identify additional points at which a small investment of time to pause, check or consider was warranted?

#### **A little homework**

The period of three minutes is of course arbitrary. Strategically however, it is aimed at providing an alternative to the discourse which constructs working with Indigenous Australian peoples as an overwhelming, uncomfortable or

unnecessary prospect. Practically, it should be seen as an opportunity to do little things well and that little things such as those examples mentioned above – a word, a sentence, an acknowledgement, a question, a pause, or even the choice to endure a confronting introduction – can have an impact, as can their absence. Professionally, it embodies a call to devote focussed time to how we as individuals and the profession to which we belong, conduct ourselves with Indigenous Australian people. Symbolically, such action stands in contrast to the generally indifferent stance taken by the profession prior to the late 1980s while being reflective and supportive of changes within the profession since (Garvey, 2010).

In broader terms, three minutes can communicate a message beyond the moment in question, with these small investments accumulating and establishing over time, a place for us in the Indigenous community and a basis for research and other kinds of therapeutic engagement (e.g., Contos, 2000; Cord-Udy, 2006; Melder, 2007; Sonn, 2007). Genuinely offered, three minutes can do much to demonstrate that we can listen as much as tell, learn as much as inform, and be directed as much as assuming control. In doing so, these accumulated minutes can challenge criticisms levelled at the profession as inaccessible, impenetrable or elitist.

The final activity consists of a list to reflect upon with a view to considering your work with Indigenous peoples. Once again, I ask you to look beyond what may seem like obvious questions, and to devote some time to how you might answer them in contexts and with people who perhaps do not share your appreciation of the profession or its lexicon. When I suggest devoting 'some time', you might consider spending three minutes with each. The choice to do so is yours except for item 10 which is compulsory.

1. How do I introduce myself?
2. How would I describe psychology?
3. How would I describe community psychology?

4. How would I describe myself as a community psychologist?
5. How would I describe how I work? What do I have to offer – what skills do I possess?
6. How would I describe myself, my profession and my way of working in a way that encourages others to consider working with me?
7. How well do I cope with silences in conversations?
8. What questions do I have about working with Indigenous Australian peoples? Who can I ask?
9. What fears or apprehensions do I have about working with Indigenous Australian peoples? Who can I tell?
10. Who is someone important to me that I will spend an additional three minutes telling why they are important to me?

### **Conclusion**

I have argued elsewhere (Garvey, 2007) that psychology and psychologists must focus on their place within, and connection to, Indigenous communities if they are to realise any true opportunities for collaboration. The present discussion has been an extension of that theme, with its message and activities aimed at encouraging us to realise the potential of minutes well spent. An additional positive for the strategy is that it is reusable, transportable and applicable in situations ranging from remote area field trips, clinical intakes, community meetings and one-to-one conversations. It provides space to consider questions as well as answers, and removes the imperative to immediately provide either.

My concern that these suggestions might be regarded as merely common sense or simplistic is counterbalanced by my ongoing involvement in conversations with psychologists and others for whom the basics of relationship building with Indigenous Australian peoples appear to be overlooked and overwhelmed by concerns for larger, systemic transformation or rescue from personal anxieties. While the large and the personal are important aspects of the equation, we must also

be willing to consider their role in the construction of barriers to working better with Indigenous Australian peoples. We cannot continue to use the potential for criticism, or the seemingly insurmountable, as reasons for ambivalence or inaction unless we are also willing to examine their foundations, as well as the reality of whether they are in fact true. While a degree of healthy scepticism from Indigenous people is to be expected, in my personal and community experience, collaboration with expertise likely to support our social and emotional wellbeing is, at the very least, regarded as an opportunity worth exploring. Inevitably, this is progressed through time devoted to fostering engagement, and most commonly realised through imperfect and fearless conversation.

My argument should not be mistaken as a gross underestimation of the work to be done or a trivialisation of the quality or quantity of that work. Indeed, there is a lot to do, not all of which is easy or necessarily achievable within the proposed three minutes, or even the next 25 years as promoted by former Aboriginal and Torres Strait Islander Social Justice Commissioner Tom Calma in reference to the timeframe required to achieve equality for Indigenous people in the area of health and life expectancy (Human Rights and Equal Opportunity Commission, 2005). However, I would like us to consider what it would be like if the time required to achieve improvements when working with Indigenous Australian peoples did not have to involve effort or resources of a magnitude that made the prospect of doing so prohibitively daunting? What if brief but mindful action that facilitated engagement, sometimes in the absence of complete cultural awareness (while enhancing the development of that awareness) supported the development of a mutually understood therapeutic or research language, and a mutual opportunity to address concerns about inequities in power, resources and outcomes? I propose that such advancements can be underscored and embodied by the idea of three minutes suggested here.

I am not so naïve as to suggest that unmitigated success and unanimous acceptance of psychologist involvement comes as a result of an extra ‘three minutes’ here or there. However in terms of exemplifying responsive, caring and respectful practice, these very basic gestures, consistently and authentically utilised, continue to be a very good place to start, at least it has been in my own imperfect and ongoing experience. For example, when you complete number 10 from the list above, try telling me that three minutes can’t make a difference in a relationship. At the very least I think such food for thought is always relevant amongst those who would bother coming together to consider “Crossing Borders, (Re)moving Barriers, Driving Change and Challenging Assumptions”. While we must remain vigilant to the larger barriers to improved psychological service provision to Indigenous people, we should also be open to the small and everyday opportunities to develop relationships, and to the truth that real and meaningful psychological work is done or avoided in the moments and minutes of our interactions.

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## Applying the Nominal Group Technique (NGT) in Community Based Action Research for Health Promotion and Disease Prevention

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*Community based health interventions (CBHIs) in which community members are central to the development of initiatives can provide the impetus for positive health and wellbeing changes and community empowerment. The application of the Nominal Group Technique (NGT) in a qualitative community based action research/health promotion program known as the Community Health Information Collaboration (CHIC) is discussed in this article. Mindful of the need to prevent the growing burden of chronic diseases and conditions in Australia, a primary aim of the CHIC program was to empower participants with health information, knowledge, skills and confidence. The program was conducted over a 10 week period and involved seven culturally and linguistically diverse participants (aged 20-50) who lived or worked in the Brimbank region of Melbourne. Week one to three of the program involved health education while the NGT session in week four and the following five sessions focussed on actions that could be undertaken to improve health and prevent disease in the community. The NGT process and results are discussed in detail and greater utilisation of the technique in community based research is encouraged.*

Community based interventions that emphasise community participation and collaboration offer vast potential for alleviating personal, social and public health problems that may exist at a community level. Community members are “experts in their own lived experiences” (Curtis, Bryce, & Treloar, 1999, pp. 202-203) and have inside knowledge of many of the problems in their community, workplaces, schools, families and social groups. Collaborating with community members can therefore broaden a researcher’s understanding of the problem of interest as well as point towards new ways of addressing it from an insider’s perspective. The other compelling reason for community collaboration is that it provides a time, space and impetus for positive changes such as community empowerment and improved health and wellbeing to occur.

Community based health interventions (CBHIs) are increasingly being commended and utilised in the area of health promotion and disease prevention (see for example, Assai, Siddiqi, & Watts, 2006; Goodman, Wandersman, Chinman, Imm, & Morrissey, 1996; Horowitz, Robinson, & Seifer, 2009; Israel, Eng, Schultz, &

Parker, 2005a; Israel, Schulz, Parker, & Becker, 1998; Leung, Yen, & Minkler, 2004; Minkler, 2006). CBHIs emphasise the use of education to empower people and provide individuals with information, skills and a supportive social environment that facilitates, reinforces, and sanctions changes (Revenson & Schiaffino, 2000). This paper provides a brief review of some key CBHI literature and discusses a recently conducted CBHI known as the Community Health Information Collaboration (CHIC). The CHIC program adopted an action research paradigm that included a health promotion, literacy or educative component; as well as giving voice to participants via a nominal group decision making session, community psychology and community governance principles and an evaluation. This paper focuses on the nominal group technique (NGT) used in the CHIC program and relates broadly to the 11th Trans-Tasman Community Psychology Conference sub-theme questions: How do we engage others? How do we create change? How do we translate theory into action? Whilst it is not within the present scope to evaluate the CHIC

program or the superiority of NGT over other methods of inquiry, this article does provide a practical example of how NGT can be used with a community group to generate and prioritise ideas for possible action to improve health in the broader community.

### **Community based health interventions**

Community based health interventions offer a promising way to tackle the growing burden of disease and mortality at a community level. For the past two and a half decades, the World Health Organisation has been supporting community based initiatives in Eastern Mediterranean countries to improve health in poor populations through actions on social determinants (Assai, et al., 2006). Community based initiatives have been successful in engaging with villagers to identify basic development needs and to improve access to basic physical, health, and social needs, tackle poverty and enhance the status of women (Assai, et al., 2006). ‘Community based research’ (CBR), ‘community based participatory research’ (CBPR) or ‘community based participatory action research’ (CBPAR) (often used interchangeably) holds similar promise for improving health as these ‘non-research’ community based health initiatives. CBR involves collaboration between community and researchers in order to generate new knowledge or understanding about a practical community issue and to bring about change (Hills & Mullett, 2000). The defining principles of CBR are that it is a planned systematic process, is relevant to the community, requires community involvement, has a problem-solving focus, focuses on societal change, is sustainable and is based on a participatory paradigm (Hills & Mullett, 2000).

Leung et al. (2004) have argued that CBPR can increase the relevancy of epidemiology by leading to a better understanding of the social context in which disease outcomes occur, while involving community partners in the research process and ensuring that action is part of the research process. Similarly, Horowitz et al. (2009) have stated that CBPR has led to a deeper understanding of the factors influencing health

and illness as well as to new ideas and innovations that are expanding opportunities for funding and academic advancement. Therefore, CBPR may be just as appealing to academics involved in university/community engagement as it is to community based practitioners with research imperatives. Ideally, the “lessons learned should inform policy and inspire structural changes in healthcare systems and in communities” (Horowitz, et al., 2009).

Following a review of numerous community-based research studies Israel, Eng, Schultz and Parker (2005a) have identified ten key principles of community-based participatory research:

1. Acknowledges community as a unit of identity
2. Builds on strengths and resources within the community
3. Facilitates a collaborative equitable, partnership in all phases of the research, involving an empowering and power-sharing process that attends to social inequalities
4. Fosters co-learning and capacity building among all partners
5. Integrates and achieves a balance between knowledge generation and intervention for mutual benefit of all partners
6. Focuses on the local relevance of public health problems and ecological perspectives that attend to the multiple determinants of health
7. Involves systems development using a cyclical and iterative process
8. Addresses health from both positive and ecological perspectives
9. Disseminates results to all partners and involves them in the wider dissemination of results.
10. Involves a long-term process and commitment to sustainability.

The CHIC program was guided by principles from public health and health promotion, health literacy, action research, community development, community psychology, community governance and community-based participatory research such as

those in the previous list. Some of these guiding principles included an ecological, holistic or wellness view of health, respect for diversity and a focus on community collaboration, empowerment, control, ownership, management and decision making.

#### *Methods in CBPR*

CBPR is one of many different approaches to research and action, “draws from a wide range of research designs and methods and pays particular attention to issues of trust, power, cultural diversity, and equity” (Israel et al., 2005a, p. 20). Some of the research methods and tools discussed in Israel et al.’s (2005b) book on CBPR methods include: surveys, individual interviews, focus groups, community forums, NGT, observational methods, including field notes and checklists, photovoice, secondary data analysis to inform action, force field analysis, mapping techniques and evaluations. Whilst some of these are traditional methods, an essential difference in CBPR seems to be the longer time frame and commitment needed to build and in many cases sustain partnerships or collaborations with community members.

#### **The nominal group technique**

NGT has been described as a technique for effective group process in CBPR partnerships because it allows equitable participation and open communication (Becker, Israel, & Alen, 2005). NGT is a group decision-making tool originally developed by Delbecq and Van de Ven in 1968 (Van De Ven & Delbecq, 1974). NGT consists of five steps as listed:

1. Generating Ideas
2. Recording Ideas
3. Discussing/Clarifying Ideas
4. Voting/Rating Ideas
5. Summing the Ratings (adapted from Van de Ven and Delbecq, 1974).

Some of the major advantages of NGT are that it produces a large number of ideas and has a greater potential for creative decision making and participant satisfaction (Van De Ven & Delbecq, 1974). The method also overcomes the problem of reluctance in participants who are reluctant to suggest ideas because of concern about being

criticised or creating conflicting (Brahm & Kleiner, 1996). NGT minimises differences and ensures relatively equal participation among participants, saves time, may decrease any tension and hostility a group might normally experience in decision making and provides a sense of closure that is often not found in less-structured group methods (Brahm & Kleiner, 1996). Being able to generate ideas without distraction or influence from more dominant members in the group, the democratic voting/rating of ideas and unanimous decision making that NGT affords, contributes to these many advantages.

Within the field of health, NGT has been used in general practice to decide on priorities of care of diabetic patients (Gallagher, Hares, Spencer, Bradshaw, & Webb, 1993); with doctors and nurses to establish clinical and health services research priorities in critical care (Vella, Goldfrad, Rowan, Bion, & Black, 2000); and with opinion leaders to consider whether to adopt or adapt the World Health Organisation practice recommendations for contraceptive use in the UK (Glasier, Brechin, Raine, & Penney, 2003). An application of NGT to identify community health priorities in northern Tanzania (Makundi et al., 2006) is a useful example of NGT at a community based level. According to Makundi et al., the study was motivated by concern for the 'burden of disease' and the need for the perspectives of marginalised groups and communities, in resource poor settings, to be integrated within the policy making and priority setting process. The research involved male and female groups consisting of community leaders/elders, patients or caregivers, religious leaders, youth leaders and women in four villages and the focus of the study was on disease problems and socio-cultural problems.

The results of the NGT showed that all the groups ranked Malaria as the number one disease problem with AIDS, hypertension and schistosomiasis also ranked highly by most of the groups. Poverty and unclean environment were identified as the leading social problems

facing health services, where respondents defined poverty as a lack of financial resources to pay for health services when they fall ill. Other problems identified included lack of drugs, lack of equipment and qualified personnel in public health facilities and gender discrimination (as a leading problem facing some of the groups of women) in the form of female genital mutilation and widow inheritance (Makundi, et al., 2006).

Although the problems identified in the Tanzanian study are very different to problems in the Australian context, the study demonstrates many important points about using the NGT in community based research. Firstly, NGT assists in demonstrating to participants that their opinions are valued. Moreover, NGT serves as both an awareness raising (health promotion) tool and an awareness assessment tool. In regards to the latter, NGT may help to assess whether participants are aware of the leading health problems and whether there are any myths or delusions about the extent of the problems. Valuing and educating community members in this way also contribute to empowerment. The Makundi et al. (2006) study also showed how culturally and community specific the NGT can be. While it is not within the scope of the present paper to discuss, Makundi et al., also found regional differences in the identified disease and social problems among the groups and sexes. This demonstrates that NGT can be useful in identifying specific issues within communities and cultures as well as detecting differences among them. NGT in this example was successfully used to identify disease and social problems but it could also be used to generate ideas or possible solutions to such problems as is the focus of the present study to which we now turn.

#### **The problem of interest and the aims of the CHIC program**

The problem of interest in this research is the growing burden of chronic diseases and conditions, particularly those identified as National Health Priority Areas (NHPAs) by the Australian government (Australian Institute of Health and Welfare, 2008). The NHPAs include:

- Arthritis and musculoskeletal conditions
- Asthma
- Cancer control
- Cardiovascular health
- Diabetes mellitus
- Injury prevention and control
- Mental health
- Obesity

The Australian government has chosen these chronic diseases and conditions for focused and targeted attention at a national level because they contribute significantly to the burden of illness and injury in the Australian community (AIHW, 2008). According to a study by the AIHW (2006), chronic diseases (including cancers) were responsible for more than 80% of the burden of disease and injury in 2004-2005 and are common with 77% of Australians having at least one long term chronic condition. Chronic conditions affect both young and old, with 10% of children aged 0 to 14 years affected by three or more long-term conditions and this percentage increasing to 80% in people aged 65 years and over. Chronic diseases are not only a drain on the health system, accounting for 70% of the total health expenditure but cause pain, suffering, disability, social exclusion and early mortality. Many people are at risk of developing chronic diseases that may be prevented with good nutrition, exercise and lifestyle. For example, the report showed that more than 85% of adults are not consuming enough vegetables, almost 50% of adults are not consuming enough fruit, one in two adults are not undertaking a sufficient amount of physical activity, around 21% of adults are smoking tobacco and 54% of adult Australians are either overweight or obese (AIHW, 2006).

The CHIC program was designed with the broader ideal of assisting the improvement of health and preventing chronic disease and mortality in Australia. The ideal is about thinking systemically while acting locally to improve community wellness; or what is often referred to in community psychology as “micro-level and macro-level” of inquiry, intervention

and analysis (Dokecki, 1992). The research as a whole included one primary aim and four sub-aims as shown in the following list.

1. To empower participants with health knowledge, skills and confidence, including:
  - 1a. To inform the community group about major health concepts and concerns in Australian society, including National Health Priority Areas, health status, determinants of health, inequalities and major causes of mortality and hospitalisations;
  - 1b. Introduce them to a range of internet based community health information resources;
  - 1c. Explore and strengthen their understanding and interests in personal and community health;
  - 1d. Involve the community group in the development of a health promotion project that would help to improve health in the broader

community.

The first general aim (1.) and the last aim (1d.) are associated with the NGT discussed in this article.

### Method

The CHIC program was conducted over a 10 week period and involved seven people who lived or worked in the Brimbank region of Melbourne, Australia. The group was similar in size to a focus group and within the range of 5-15 participants recommended for conducting NGT (Becker, et al., 2005). The group was culturally and linguistically diverse (CALD) and consisted of four Vietnamese people (one male and three females) and three females from the Maltese, Filipino and Latin-American communities, respectively. The participants' ages ranged from early 20s to over 50. An outline of the 10 week CHIC program is shown

Table 1  
*CHIC program outline and session details*

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Week 1: Introductions – This first session will involve meeting other community members in the group and introducing our interests in health. The CHIC coordinator will provide an overview of the project, including the new CHIC website. Some favourite health websites/topics will be explored including Body Mass Index and fruit and veggie calculators, personalised healthy food pyramids, healthy living calendar, world's healthiest foods and healthy recipe sites.

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Week 2: Community Health Evidence Base (CHEB) – A power point presentation of the CHEB resource which is an informative summary of public health issues and health statistics in Australia, Victoria and Victorian communities will be presented in this session. Issues such as life expectancy, causes of death and illness and differences in health outcomes due to factors such as age, gender and geographical location are presented.

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Week 3: Thinking about health in our community – In this session we will focus on the Brimbank community and will discuss some of the community health issues of interest to us as a community. Are some health issues more urgent/important to us? What are some of the reasons for these particular health problems? Is our community healthy?

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Week 4: Good ideas and choosing a manageable task – Today, we will 'brainstorm' ideas about actions that can be undertaken to improve health in our community. We will list our good ideas on project paper and prioritise and decide on a manageable task using the 'Nominal Group Technique'.

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Week 5: Planning for success – In this session we will develop a plan of action for our chosen idea. What needs to be done? Who will do what? Who can help? Do we need to apply for funding to enable the undertaking of the project? We will have the next 4 weeks to undertake our project or get it to a stage where it could be undertaken (if it is a large project).

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Week 6-9: Action stages 1 to 4

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Week 10: Celebrate our achievements – Program members will be asked to bring in a small plate of healthy food to share. We will have a chance to reflect on and evaluate our experience and opinions of the program and celebrate our achievements.

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in Table 1. This outline formed part of a colourful brochure and flier advertised during the recruitment stage of the research. Participants were recruited by distributing the brochure and flier to various public services in the Brimbank region including: Isis Primary Care, Migrant Resource Centre, Good Shepherd Youth and Family Services and St Albans, Keilor and Deer Park public libraries.

The program was held in a large refurbished classroom at Victoria University, St Albans Campus, Melbourne. As shown in Table 1, the program consisted of both education and research components and “data collection” was not the intention in every session. For example, session one was an introductory rapport building session and, together with session two and three, was designed to be informative and educative. Week one to three of the program included introducing the group to a range of internet based health information and disease prevention resources; epidemiological evidence about the extent of the chronic disease problem; and focused information on the health and wellbeing of the Brimbank community. On the other hand, the nominal group technique in session four was a more formal research method that yielded data. Sessions five to nine involved a process of planning for action that could improve health in the community and which could be observed, documented and evaluated by the researcher. A formal evaluation with participants was also undertaken at the end of the program. However, once again the main focus of the present work is on one part of the CHIC program – the application of the Nominal Group Technique.

#### *NGT process*

An adapted form of NGT was used in the fourth session of the CHIC program to generate ideas about actions that could be undertaken to improve health in the Brimbank community and to prioritise and decide on a manageable task. A six-slide PowerPoint presentation demonstrating the method (Totikidis, 2009) was developed and shown to participants prior to beginning. The first slide consisted of an overview of five steps in NGT followed by an explanation of each step of

the process as follows.

#### *1. Generating Ideas*

- In this step, each person is required to write down as many ideas as they think of about possible projects we could undertake to improve health in the community.

This is a quiet phase when you write your ideas without discussing with any one else.

#### *2. Recording Ideas*

- We will then transfer all our good ideas (to promote health in our community) onto a chart for everyone to see.

#### *3. Discussing/Clarifying Ideas*

- In this step we discuss the ideas so that there are no misunderstandings about what they mean.

The person who generated the idea may describe the idea and other members of the group can ask questions.

#### *4. Voting/Rating Ideas*

- We are going to use 1 to 5 stars to rate our favourite ideas.
- You will be given five coloured cards with 1 to 5 stars on each one as shown below.
- You will be required to write the name of the five ideas you like the most on the cards.

Write one idea on each card using the preference guide on the right.

#### *5. Summing the Ratings*

- The ratings will now be transferred to the chart.
- The idea with the highest total stars/score will be the ‘group decision’ about which idea we will develop further in the coming weeks to help improve health in the community.

In the first step, participants were asked to reflect on something we could do or plan to do as a team to improve health in the community. It was explained that it would have to be a reasonably small project that could be designed and implemented with around \$500 in funds from the available budget. The researcher participated as both a facilitator and participant in the NGT in order to demonstrate the method and to engage as

one of the CHIC team. Each participant was given note paper and a pen and was asked to quietly and independently list their ideas. When participants were finished, the notes were collected and all the ideas were transferred to an Excel data sheet that was projected onto a big screen. Each idea was then discussed by the person who suggested it so that everyone was clear about its meaning. Some ideas that were very similar were combined.

Following the generation, listing and clarification of ideas as described in steps 1 to 3, participants were asked to rate their favourite ideas using a simplified five-card rating system developed by the present researcher (step 4). This involved giving each person a set of five small coloured cards consisting of a rating from one to five numbers and stars on each card and asking them to write their five favorite ideas on the cards. The usual procedure in NGT is that all the ideas are rated by each person. Nevertheless, the researcher had used this system on a previous occasion several years ago and found that rating errors were very easily made by participants. For example, some ideas were given the same rating which then confused the whole numbering sequence. A lesson learned was that it is a difficult and lengthy task to rate 50 or so ideas! Moreover, since the aim of the session was to arrive at a single idea for action, there seemed little point in rating every single idea. An example of the card rating system is shown in Table 2.

Table 2

*Five degree idea rating system used in the NGT*

Note: The size of each card was 38mm x 69mm. Rows above are shown narrower than actual cards used.

Rating on each card	Description
1*	1 star - Not a bad idea (purple card)
2**	2 star - A good idea (blue card)
3***	3 star - A very good idea (green card)
4****	4 star - An excellent idea (orange card)
5*****	5 star - My most favourite idea (yellow card)

When participants finished writing down and rating their five favourite ideas, each person in turn read out the responses while the researcher transferred them to the Excel sheet. The ratings for each idea were then summed and the item totals were ranked so the highest rating was at the top of the datasheet.

### NGT results

The technique yielded 48 excellent ideas that could be undertaken to improve health in the community. Table 3 consists of the 20 favourite ideas that received a 1 to 5 rating from at least one person. The top rated idea received a score of 16 out of a possible 40 which indicates quite a dispersed rating from participants. That is, not everyone gave this particular idea the top score of five.

The main themes that emerged included strategies relating to *health information, awareness or education*; strategies focused on *healthy eating, food and cooking*; and strategies focused on particular subgroups or locations such as *schools, communities, workplaces and clubs*.

The remaining 18 ideas that were generated but not rated within the top five by participants are listed below. The themes identified earlier also apply to the present list and in addition a theme related to *exercise/activities* and to *competitions/twinning* can also be identified in the list. *Partnering* (e.g., with

Table 3  
*Participants' ratings of five favourite ideas to promote health in our community*

Good Ideas Generated	Participant Number								Total
	1	2	3	4	5	6	7	8	
Provide free information – free cooking class, recipes	1	4	4	1	5		1		16
Healthy school lunches (healthy lunchbox competition)				3			5	4	12
Advocacy materials – develop brochure/pamphlets and distribute to library, schools, churches, hospital, shops	5				3				8
Health awareness Community groups/similar to neighbourhood watch ('Health Watchers')				3	1	1		3	8
Competitions among various communities	2	2	2		2				8
Information sessions run in school, welfare clubs, groups, doctor				4		4			8
Focus on young people's health		1	1		4				6
Supermarket and fresh food market tours with a qualified nutritionist		3					3		6
Conduct a forum about health promotion					5				5
Coordinate with Local Government Units – for promotion in their locality (particularly to health department)				5					5
Health awareness day at a school level								5	5
More education programs at grass root levels e.g., senior citizens clubs, youth clubs						5			5
Talk with the group about the importance of health promotion					5				5
Establish steering committees	4								4
Healthy cooking sessions at community level							4		4
Health promotion in the workplace – occupational, health & safety, nutrition				2				2	4
Media releases (local newspaper)						2		1	3
Health awareness day at a community level						3			3
Advertise on SBS*	3								3
Community information session							2		2

Note: \* SBS (Special Broadcasting Service) is Australia's multicultural and multilingual radio broadcaster.

local government and local agencies) was another theme that emerged among the responses

- Network with different welfare agencies to advocate/promote health nutrition
- Health information sessions for people living in different areas
- Programs for primary and high schools
- Articles for newspaper, magazines, school news letter
- Fliers to drop at libraries & doctors' clinics
- Health seminar
- Talk shows on community radio

- Cooking programs to promote healthy eating
- Aerobic, swimming, tai chi, yoga meditation programs for communities
- Walking groups
- Disadvantaged groups – unemployed (health)
- Twinning ethnic minority groups regarding health programs share ideas, recipes
- Free Brimbank health calendar
- Poster competition – Healthy eating
- Community education/awareness – discussion fliers to drop libraries, doctors
- Organise more short courses about good food and healthy life styles

After further group discussion of the results, it was decided that some of the top rating ideas could be combined into a single project. For example, the provision of free health information, brochures and pamphlets, free cooking class and recipes could be part of a healthy school lunch competition or festival. Such a program could involve parents as well as children. During the session we discussed the importance of early intervention around healthy eating and adequate exercise for children especially in light of the growing rate of obesity and diabetes among children. One of the CHIC members who worked in a local primary school then shared a story with us that formed a guiding metaphor for our work. As the (Vietnamese) multicultural officer for the school, this particular member is often called upon to discuss issues concerning the wellbeing of a child with his or her parents. Healthy food or the lack of it was a common problem and she mentioned that it was not uncommon to find that a child had two packets of potato chips or sweets and lollies with not much or nothing else in their lunch box. Often, parents did not know how to deal with this problem and reported that the child refused to eat healthy food and would either bring it back home or throw it away. This metaphor of *the child with two packets of potato chips or sweets for lunch* demonstrates the importance of health promotion at the school level.

Although it is not within the scope of this paper to discuss, our guiding metaphor led to the development and implementation of a successful

school wide health promotion project called the 'Healthy Munch, Lunch and Crunch Program'. The program included involving children from a local primary school in learning about health and healthy eating, a healthy art show, a free healthy lunch day, distributing national nutritional guidelines to all parents and children, and forming new partnerships and associations with organisations interested in continuing the health promotion effort in the school and beyond.

Other CHIC activities included initiating and participating in two media releases with a local newspaper and the university and a public celebration with healthy food in the final week. The celebration attendees consisted of the CHIC team members, students/staff of the university, two politicians with strong interests in health and the Brimbank community and the principal, assistant principal, teachers and parents from the local primary school. Service providers and social workers from various organisations, including Centrelink, Western Region Outreach Service, Good Shepherd Youth and Family Service and the Indo-Chinese Elderly Refugee Association also attended. A summary version of the health promotion messages of the CHIC program together with talks on health by the politicians were delivered at the celebration, thereby extending the reach of the health promotion messages to the broader community.

### Discussion

The nominal group technique is a useful 'brainstorming' or idea generating method that also simplifies group decision making processes. An application of NGT in a community based action research/health promotion program known as the Community Health Information Collaboration was discussed in this article to enable other community researchers to utilise the method in similar community based action research. The research showed that NGT can be used

just as well for generating solutions to public health problems as it can be for identifying problems as shown in the Makundi et al. (2006) study discussed earlier. Some of the research observations/reflections arising from this study were that the NGT process itself was fun to use in the community group and was no more difficult than a bingo game. Participants showed an inquisitive interest in the technique and laughed and engaged with each others ideas during the feedback stages. However, two to three hours are needed to complete the technique and thorough explanation of the steps is needed to ensure there are no misunderstandings about what to do. This is especially important in the final rating on coloured cards to ensure participants know the difference between a rating of one and rating of five and so that they know that any idea can be rated (not just the ones that they personally generated).

Projecting the instructions on the screen at each step and being aware of the participant experience at all times are keys to the success of the technique, and may be particularly important in a CALD group. The NGT facilitator must also ask questions to gauge the satisfaction and thinking of the group at various stages.

Two major benefits of the NGT were the generation of so many practical ideas and the mutual sense of accomplishment felt by the group. This can be gauged by a number of positive comments made by participants at the end of the session and by the high ratings given to the evaluation statement: "I believe we generated some great ideas on how to promote health in our community" (rated 5 on a scale of 1 to 5 by each participant). Although further planning was required after the initial generation of ideas, the process was smooth and amicable. That is, there was no observed conflict of any kind and a general acceptance and support of the decision making process and top rated ideas. On the other hand, most of the participants felt that some of the ideas could be combined to form a single project so some flexibility as well as further discussion after generating ideas is advised. As mentioned elsewhere, the exercise

led to the development of a successful school wide health promotion program involving children and parents, media releases and a public celebration.

A point to note is that the method of recruitment attracted participants who already had an interest in health, and it is not known whether the tool would be as successful with a sample that has no interest or knowledge of the subject matter or community. One of the disbenefits of the NGT was the lack of 'rich data' that is characteristic of other qualitative methods such as focus group and individual interviews. Moreover, although NGT is suitable for small sample sizes, a small sample size precludes any comparisons of results on the basis of factors such as culture, age and gender. On the other hand, the advantage of NGT over these methods is the very 'succinct' and practical information generated and little need for in depth analysis. This makes it a valuable method for action and applied research where the time saved can be used in developing and implementing better health promotion programs for the community.

The relevant and practical themes arising from the research also showed that participants gained sufficient understanding and knowledge from the educative components of the program to be able to propose particular interventions to promote health and prevent chronic disease in the community. Returning again to the 11th Trans-Tasman Community Psychology Conference sub-themes on engaging others, creating change and translating theory into action; this research makes a contribution to knowledge about methods that can successfully engage community members in the decision making processes concerning community action and change.

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## Resilience: A Definition in Context

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*Resilience is a well researched phenomenon in the literature. The notion of ‘bouncing back’ has been the predominant feature of definitions of resilience. This paper examines four research studies within four different contexts to understand the concept of resilience within a broader systems view inclusive of the development of individuals and the contexts in which resilience is supported. Based upon four separate qualitative and quantitative research studies (i.e., adolescents in school, women and domestic violence, children in separated families and students adjusting to university), this paper endeavours to propose a broader understanding of resilience. In acknowledging the context and the developing nature of resilience over the lifespan the authors offer a new definition of resilience as ‘the potential to exhibit resourcefulness by using available internal and external recourses in response to different contextual and developmental challenges’.*

During the past few decades there has been a proliferation of research on resilience. This interest in resilience is not surprising as many disciplines (psychology, social work) move from a deficit, ‘glass half empty’ view of human nature to a positive, salutogenic, ‘glass half full’ approach. Contemporary psychological research has a much more semi-permeable quality with psychological researchers throwing caution to the wind and involving themselves in contexts, and with methods, that in the past were challenging. Masten and Wright (2010) present an overview of the four waves of resilience research in which they propose that initially resilience research focused on the definitions and descriptions of resilience; the second wave focused on the variables associated with resilience: the third wave sought to test resilience intervention ideas; and the fourth wave, that is current resilience research, seeks to advance resilience studies in integrative ways to “better understand the complex processes that lead to resilience” (p. 214).

In order to place our current understanding of, and position on, resilience, the authors will briefly outline the key issues in resilience research and present the most contemporary definitions in the field. This will be followed by an exploration of resilience through four separate case studies where each presents data on participants, analysis, and key findings. Key themes relevant to resilience are identified and

discussed for each case study. The paper concludes with a discussion of the implications of the research, and a proposed definition of resilience.

Borrowed first from the physical sciences, early research on resilience was not initially characterised as ‘resilience’ research. Early resilience research focused on risk factors to chronic and acute illness for adults (Dawber, Meadors, & Moore, 1951), and for children, the focus was on vulnerability in impoverished and troubled families (Werner & Smith, 1982). Therefore the negative effects of adversity were an important focus for researchers in defining resilience outcomes. People were deemed resilient if they did not develop problems (Garmezy, Masten, & Tellegen, 1984). Even today the vast majority of research on resilience has focused on at-risk children and adolescents (Cicchetti & Rogosch, 2007; Curtis & Cicchetti, 2007; Flores, Cicchetti, & Rogosch, 2005; Luthar, Cicchetti & Becker, 2000; Martinez-Torteya, Bogat, von Eye, & Levendosky, 2009; Ribbens McCarthy, 2006) and therefore many resilience intervention programmes have been developed for children and adolescents. However, despite numerous and significant risk factors cited in the literature, not all children and adolescents who were considered ‘at-risk’ developed mental health issues/problems (Ungar, 2005a; Ungar, 2005b).

In terms of defining resilience, there is

controversy in the literature as to whether resilience is a characteristic/personal quality, a process, or an outcome (Ahern, Ark, & Byers, 2008). In defining resilience as a personal quality, Ahern et al. (2008) argues that resilience is an “adaptive stress resistant personal quality” (p. 32), whereas resilience defined as a process is described as “a dynamic process that is influenced by both neural and psychological self-organisations, as well as the transaction between the ecological context and the developing organism” (Curtis & Cicchetti, 2007, p. 811). However, when defined as an outcome, resilience is thought of as “a class of phenomena characterised by good outcomes in spite of serious threats to adaptation or development” (Masten, 2001, p. 228). Indeed work by Rutter (2007) goes beyond the conceptualisation of resilience being about only the individual and has included recognition of the environment. Similarly, Masten and Wright (2010) argue strongly for the conceptualisation of resilience to go beyond being an individual characteristic and not bounded within an organism; instead, they view resilience as a dynamic process and interaction between the individual and their ever-changing environment.

Other authors emphasise that resilience is a phenomenon that is characterised by both outcomes and processes. For example, resilience is characterised as a phenomenon which is defined by “the success (positive developmental outcomes) of the (coping) process involved (given the circumstance)” (Leipold & Greve, 2009, p. 41). In contrast to being guided by a specific philosophical orientation, participants of qualitative studies have been asked to define the concept of resilience (Hegney et al., 2007; Schilling, 2008; Ungar et al., 2007). Interestingly one participant of Hegney et al.’s (2007) study on individual resilience in rural people in Queensland, Australia, described resilience as “a bit like a rubber ball. If it’s under pressure or something it can actually spring back to its size and shape and carry on without sustaining undue damage” (p. 6). Indeed this image of resilience as a ‘rubber ball’ and ‘bouncing back’ is an expression that has dominated the understanding of resilience and the definition used in research studies and the literature generally (Smith, Dalen, Wiggins, Tooley, Christopher, & Bernard, 2008).

Nevertheless, despite the vast range of definitions, there is some agreement in the field that to determine if someone is displaying a resilient profile/resilience, two elements must be present: namely, adversity (i.e., a high-risk situation or threat) and successful adaptation/competence (Luthar et al., 2000; Masten, 2001; Schilling, 2008). Adversity is evaluated according to negative life circumstances (Schilling, 2008) and adaptation is defined as successful performance on age-developmental tasks. More recently the work of Ungar through the Resilience Research Centre in Canada has galvanised much interest and discussion around resilience. Ungar (2008) outlines a new ecologically focused definition:

*In the context of exposure to significant adversity, whether psychological, environmental, or both, resilience is both the capacity of individuals to navigate their way to health-sustaining resources, including opportunities to experience feelings of well-being, and a condition of the individual family, community and culture to provide these health resources and experiences in culturally meaningful ways (p. 225).*

Ungar’s (2008) understanding and definition of resilience highlights the ideas that individual attributes, family aspects and social environment (as well as culture) all play an important role in resilience. Therefore resilience can be viewed as a multidimensional construct. In order to try and understand the multidimensionality of the resilience construct the authors undertook to investigate how resilience can be understood in four different contexts and research studies. These contexts are not unique but they do provide examples of different ages, genders, and developmental stages to better understand the importance of context and development in resilience research. The contexts explored are, adolescents in schools, domestic violence within families, separation and divorce and adjustment to university. Each of these contexts provides a unique insight into the way in which resilience is

understood.

*Case Study One – Self-Efficacy, Sense of Belonging and Social Support as Predictors of Resilience in Adolescents.*

Adolescence is a transitional period defined by major physical, cognitive, social and emotional changes. These changes have been identified as major stressors, although some individuals cope well with these changes, others struggle to adapt. These individual differences in coping may be due to the ability to be resilient. The degree to which a person is resilient can be influenced and determined by the presence of protective factors. Social support, sense of belonging and self-efficacy are factors that may be considered as protective against risk. The current study aimed to examine whether social support, sense of belonging and self-efficacy would significantly predict resilience.

Participants were 60 grade nine and ten students who completed four self-report questionnaires: Psychological Sense of School Membership (Goodenow, 1993), Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet, & Farley, 1988), the General Scale of Self-efficacy (Schwarzer & Jerusalem, 1995), and the Adolescent Resilience Scale (Hjemdal, Friborg, Stiles, Martinussen, & Rosenvinge, 2006) to measure levels of social support, sense of belonging, self-efficacy, and resilience. Standard multiple regression analysis revealed that the predictor variables in combination significantly predicted resilience (25.2% variance explained). However, results indicated that only social support independently predicted resilience (Nowicki, 2008).

*Case Study Two – Situational-Contextual Factors that Mediate the Impact of Exposure of Domestic Violence on Children: A Retrospective Study of Adult Women Residing in Perth, Western Australia.*

Much of the existing research on children and domestic violence has focused on the negative consequences of witnessing such violence. However, in recent years several researchers (Carlson, 2000; Criss, Pettit, Bates, Dodge, & Lapp, 2002) have endeavoured to identify factors that

promote resilience among children who are exposed to domestic violence. Due to the paucity of qualitative research studies examining children's experiences of domestic violence exposure as well as the factors that mediate the impact of witnessing such violence, this study aimed to address these gaps in the research. Specifically, this study aimed to explore women's experiences of witnessing domestic violence during their childhood and adolescent years as well as the factors that influenced their ability to cope with witnessing such violence. Six women who had witnessed domestic violence during childhood or adolescence were interviewed using a qualitative research design with an underlying phenomenological and resilience framework. Six dominant themes, each with a number of subthemes, emerged from the data. These were: the context of the violence, the characteristics of the violence, the impact of domestic violence, coping and survival strategies and outcomes (O'Bryan, 2008).

*Case Study Three – Divorce Transitions: Identifying Risk and Understanding Resilience in Children's Adjustment to Parental Separation.*

The elevated risks that divorce presents for children and the associated negative consequences have been well documented (Pike, Cohen & Pooley, 2008). However, significantly less attention has been devoted towards identifying factors that promote resilience among children of divorce. The study attempted to rectify this imbalance in the literature by exploring children's own perspectives of their adjustment to parental divorce. Specifically, the study examined how children determine what it means for parents to separate and how they understand the ways in which they survive the divorce experience. Eight children (six female and two male) from separated families were interviewed using a qualitative research design within a phenomenological framework. Six themes emerged from the research: the significance of age at time of parental separation; continuity

and flexibility in seeing dad; co-residence and closeness: mothers as important sources of support; the positive impact of the step-father; increasing responsibility and positive child attributes, and It was all for the best (Kint, 2007).

*Case Study Four – Differences in Resilience and University Adjustment between School Leaver and Mature Age University Students.*

Previous research has indicated that mature age and school leaver students have different experiences when transitioning to the university environment. It is suggested that the transition to university is a major life transition and may be a period of great stress. For mature age students and school leaver students, the impacts upon adjustment to university are varied during the transition to university study. It has been proposed that for successful university adjustment, high levels of resilience are needed. Three hypotheses were tested with a sample of undergraduate students ( $n = 63$ ). All participants responded to the Resilience Scale for Adults (Friborg, Hjemdal, Rosenvinge, & Martinussen, 2003) and the Student Adaptation to College Questionnaire (Baker & Siryk, 1984). Hypothesis one, that there is a relationship between resilience and adjustment, was supported, with 31.9 percent of the variance in adjustment can be accounted for by resilience. Hypothesis two, that there is a difference in university adjustment between school leaver and mature age students, and hypothesis three, that mature age students would exhibit higher levels of resilience than school leavers, were both not supported (Munro & Pooley, 2009).

### **Discussion**

In this discussion we will present our findings under two major sections. The first section examines what each case study reveals about resilience in the specific contexts. The second section will provide an overall discussion of the findings of the case studies, the implications, and propose a new definition for resilience.

#### *The Case Studies*

Case study one provides support for the relationship between resilience and protective factors. The protective factors specifically examined were sense of belonging (SoB) which is defined as a

“sense of being accepted, valued, included, and encouraged by others...and of feeling oneself to be an important part of ...life and activity...” (Goodenow, 1993, p. 25); social support (SS) refers to a transaction between one person and another, which may be about providing information, an appraisal, showing emotions or by aiding the person (Murphy, 1987); and self-efficacy (SE), developed by a number of authors, most notably, Bandura (1977, 1986), which is seen as the mediator between knowledge and action and is defined as “people’s judgments of their capabilities to organize and execute courses of action required to attain designated types of performances” (Bandura, 1986, p. 391). Self-efficacy refers a person’s appraisal of their ability to act in a given situation regardless of the skill repertoire they may have (Gist & Mitchell, 1992; Rutter, 1985), and is regarded as an important motivational construct (Gist & Mitchell, 1992).

In Nowicki’s (2008) study, the regression model (SoB, SS and SE) accounted for 25% of the resilience score, suggesting that connection to something outside themselves (SoB), the ability to connect (SE), and external resources (SS) are important to adolescent resilience. Social support was the significant predicting factor which substantiates other research that argues that social support is a mediator for transition experiences (Stumpers, Breen, Cohen, Pooley & Pike, 2005). Previous research has reported that the positive effects of an individual’s social support are derived not only from the support actually available, but also their perception of that support (Cauce, Felner, & Primavera, 1982). Therefore, within the adolescent transition processes, the ability to recognise, want and seek support, as well as having the opportunity for support, are all important interactive mechanisms which contribute to the resilience of adolescents.

For the women in Case Study Two, the recollection of their experiences is a reflection of their ability to adapt from childhood and the influence of this on their longitudinal adaptive coping process. There is recognition of supports within their childhood contexts that enabled them to survive, as well recognition for the individual

characteristics they possessed. Understanding these internal characteristics gave them the confidence to find coping strategies as a child but also as an adult.

In what is essentially a quintessential risk environment, these women articulated successful adaptation for later coping and recognise resources, both internal and external. What is also interesting is that the women described the importance of the context of the domestic violence in that they talked about their position in the family and how this impacted on their experience. Finally they also recognised the use of adaptive mechanisms for themselves as mothers with their own families.

In Case Study Three, the children articulated the adaptation to a new family world in that they reconstruct their family to include flexible access to both parents, obtain support from their mother, and include step fathers when needed. For these children, understanding the importance and flexibility of the family system supports these children to recognise the separation as a positive outcome in their situation. Further to this, these children displayed the developmental challenges of adaptation; they have moved on and their cognitive ability (memory) also creates a new reality. Developmentally, taking on new responsibilities is a positive adaptive process. Given that figures on marriage and separation indicate that less than one third of marriages go beyond 10 years it would seem that many children at sometime will have to face the challenge of family separation. Do we look at separation as a new era of transitions that children are supposed to deal with?

The final Case Study supported the relationship between resilience and adjustment in the transition to university within a student population. There were no reported differences between school leavers and mature age entry students; however other studies indicate that whilst there may be no difference quantitatively, qualitatively the experiences are different and therefore the adversities may be different (Urquhart & Pooley, 2007), and this may culminate in a similar need for resilience in adjustment to the university context. This may account for adjustment contributing 31.9% to the variation in resilience in the Munro and Pooley (2009) study.

### *Overall Discussion*

If these case studies are examined together, a number of important considerations with respect to resilience start to emerge. There is support from previous research, the design and the outcomes of the case studies, for the role and importance of internal resources. Self efficacy, coping, and sense of belonging are important internal resources which contribute to resilience in the contexts presented in this paper. The provision and facilitation of external resources such as social support have also shown to be important by design and outcome in these different contexts. The ability and opportunity, for any of the participants in these case studies, to recognise, make use of or have the supports available is vital to a resilience process/interaction.

What is also overwhelmingly clear is the support for examining resilience in different contexts and highlighting how the context interacts with the processes of resilience. The opportunities for individuals are different, the needs are different, and the extent to which individuals can make use of these opportunities is different. All of these variables change over time; understanding that development in all of these aspects is vital to our understanding of the dynamics of resilience. The importance of context and development is that if one only considers resilience from an individual perspective, then the tendency to 'blame the victim' would become apparent, making it the individual's responsibility to work on themselves to make themselves more resilient. These case studies indicate that resilience is a multidimensional, multi-level construct.

Whilst the more current definitions of resilience do recognise the importance of context, the lifespan approach to understanding the importance of development and transitions is not a focal point. The authors therefore propose a new definition of resilience: "The potential to exhibit resourcefulness by using available internal and external recourses in response to different contextual and developmental challenges", in recognition of

many of the aspects that these case studies exemplify. These aspects are presented in the literature; however, they are generally presented in isolation. Therefore we have taken the opportunity to combine the significant aspects and specifically highlight and present what the authors think is important to the resilience field.

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## **Evaluation of the 11th Trans-Tasman Community Psychology Conference: Exploring Boundaries, Expanding Frontiers, July 2009, Fremantle, Western Australia**

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Glen Scott-Pillow  
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*Qualitative evaluation of the 11<sup>th</sup> Trans-Tasman Community Psychology Conference held at the port city of Fremantle, Western Australia showed that the conference was well received, with the atmosphere and diverse themes being appreciated by the 90 attendees. The broad conference topic of frontiers was broken down into four subthemes of crossing borders, removing barriers, driving change and challenging assumptions. The range of papers actually presented reflected the many socially concerned and enquiring voices in community psychology. Attendees appreciated the strategy of pairing keynote speakers with practice presentations, although many wished there had been opportunity for more discussion in the formal paper sessions. To promote action, some attendees suggested widening the net to include non-psychologists such as those involved in framing State and National policy in Australia and in New Zealand, together with broader representation from community agencies and the legal profession. These and other feedback themes are offered as considered input for the next Trans-Tasman conference. Social highlights of this conference were the welcome function held at a local brewery in Fremantle, and the performance of the Spirit of the Streets Choir at the Conference Dinner.*

In 2009, the 11<sup>th</sup> Trans-Tasman Community Psychology Conference was held at the University of Notre Dame in Fremantle in Western Australia. Local, national and international speakers were invited to attend on topics of community interest, where the overall theme for the conference was “Exploring boundaries, expanding frontiers”. The four listed sub-themes were: crossing borders, removing barriers, driving change and challenging assumptions. ‘Crossing borders’ invites working in diverse settings, applying community psychology in extending areas and learning from this engagement. ‘(Re)moving barriers’ involves barriers involved understanding what hurdles currently impede our practice and how they might be overcome. Driving change suggests questions such as: How do we create change? How do we translate theory to action? What skills do we require? How can training be improved? Where are we headed? The fourth subtheme of ‘challenging assumptions’ is associated with the question of how to turn the lens of serious reflection and questioning onto

our own work.

There is a strong acknowledgement of the importance of social justice value within community psychology (e.g., Fisher, Gridley, Thomas & Bishop, 2008), reflected in training and practice associated with disadvantage and empowerment, including Indigenous concerns, the situation of single mothers, family violence, social health, immigration and community building. As expected, the 2010 conference papers largely reflected these foci and extended into conceptual and developmental issues in community psychology.

The Trans-Tasman series of conferences enables our specialty to celebrate community psychology both here in Australia and also in New Zealand. The conference series began on Pakatoa Island in Auckland in 1989 with an emphasis on experiential learning during the conference and through its activities (Fisher et al., 2008). Active engagement with local social and political contexts was a key background to this experiential learning. There were 90 attendees over the four day period of the present

Table 1  
*Locations and Occupational Context of Attendees*

From WA 26/90 (62%)	From other Aust. States 20/90 (22%)	International 14/90 (16%)
Students 23/76 (30%)	Academic Staff 27/76 (36%)	Practitioners 26/76 (34%)

(11<sup>th</sup>) conference, with affiliations to universities, community agencies, government departments, and private organisations and practice.

This paper describes a formal evaluation of the conference commissioned by the Organising Committee. The evaluation was qualitative, with questions regarding the content and supporting organisation of the conference.

#### Method

##### Participants

Of the 90 attendees, 28 replied to the questionnaire either through hard or soft copy. This yielded a response rate of 31%. Table 1 below shows the characteristics of the whole sample of attendees, indicating that 62% of attendees were from Western Australia. The primary occupation was relatively evenly distributed between student, academic staff and practitioners, based on those 76 participants who gave this information in their enrolment details.

##### Sources of information

Respondents used a two page semi-structured open-ended questionnaire (see Appendix) to organise their responses. In addition, enrolment information was used to determine the characteristics of attendees (see Table 1).

##### Analysis

Although most respondents were relatively brief with their comments, some took the time to write longer entries. The qualitative data were entered on a spreadsheet and thematic content analysis as described by Creswell (2009) was employed. Both researchers initially read all of the questionnaires several times to get an overall

sense of the data, and then identified any biases and questions they had through memoing. Significant concepts, sentences and statements were highlighted.

Both researchers independently reduced the data by coding the material into themes, and then met to resolve any differences in their coding. The responses were cut and pasted, and classified under the different themes. Major themes were then established by grouping together minor themes, and a summary statement was written that described the underlying data. Where possible, quotations from actual respondent returns were used, and these higher level analyses were then written up to form the reported findings.

#### Conference Content

##### Reasons for Attending

Some respondents were regular attendees of the Trans-Tasman conference, with them reporting that “I always attend these conferences – they are my homeplace in psychology”, or “I have a very strong identification with community psychology and want to maintain and develop this connection”. Most, however, were “curious” and “wanted to learn more about community psychology”.

##### Experiences of the Conference

Most respondents considered the group of themes of the conference worked well. One remarked on the “lovely synthesis of perspectives and diverse people. The conference ran smoothly, organisers are lovely. I think Freo facilitates these discussions better than the City, so well picked.” Another said “For me, this was

a dark horse of a conference. I was impressed with the quality of speakers and the organisation of the event.” Yet another “found the themes very relevant to community psychology as it is still evolving. I enjoyed the presentations and found most of them to be very relevant. The mix of practice and theory was great. Keynote speakers were informative and relevant to the Australian context.”

The diversity, scope and variety of content received positive feedback from many. Attendees commented on the “good variety”, “scope of issues”, “attention to diversity”, “diversity of speaker perspectives”, and “breadth of information presented”. One person commented that “the content was interesting and well balanced”, while another said they thought the speakers were “all relevant to current, social issues here and overseas”. Another comment was “The content was very informative and inspiring. The amount and diversity of the content showed all perspectives”, while another respondent wrote “A good cover of themes and diversity of keynote presenters”. One student participant remarked that the conference themes were “very diverse, with a range of speakers not only from Perth or Australia but overseas as well. Good for a student to see the scope”. A representative summary of the positive feedback in this area was the comment “I think (the conference was) just a lovely synthesis of perspectives and diverse people.”

Indigenous and other topics relevant to the region and Australia in general were highlighted in the responses. The theme on Indigenous issues, in particular, was received well with several participants indicating that they “enjoyed the Indigenous focus”. One person attended to “hear about community psychology in Australia and the region” being “particularly interested in the Indigenous issues being discussed”. Others liked the focus on other disadvantaged groups such as the homeless, and young mothers, while others singled out the critical community psychology dialogue as being memorable. Another was surprised to learn that “the *Big Issue* actually does help homeless people”.

One feature of the conference was that all keynote speakers were paired with practice presentations. Attendees liked the “theory, action research, community perspectives, having an overall theme for one day”. Many enjoyed the keynote speakers, with comments ranging from “keynote speakers were fantastic”, “being very informative and interesting”, and “inspirational”. Another commented on the “balance between research and community projects – so theory seen in action!”

Although the larger part of the feedback was positive, as in the examples given, there was also constructively critical and negative feedback. A few found “some presentations to be confusing and not really community psychology”, with others remarking that “some speakers were not acquainted with community psychology”. One suggestion was that a definition of community psychology would have been helpful; another recognised this issue, but considered that community psychology was still evolving.

One attendee stated that “a lot of speakers spoke about things in a narrow focus, which didn’t seem to be easily generalised into larger solutions for community problems, for example, empowerment and resilience. The presenters also seemed to provide their information, but didn’t really have any information on how this could help large groups of people, or help community problems.” Instead, this respondent suggested that topics could be opened up to

*...presenters from differing backgrounds – they mostly seemed to be from psychology or counselling... I would also have set aside positions for people from different backgrounds, for example, government, law, and various community agencies. This would have provided for discussion from people from a variety of contexts and beliefs, and would provide better opportunities for networking. This would also mean that it wouldn’t just be a bunch of*

*psychologists speaking to one another, and may also lead to some sort of action.*

### **Timing, Scheduling and Use of Classrooms**

Several attendees mentioned liking the length of the event and allocation of time between presentations and other activities. Comments included, “sessions were a great length of time”, “length of conference just right”, and “(good) balance of time between keynotes”. However, the length of keynote sessions were identified as a concern, reflected in such comments as “Not enough time left for questions and discussion”, “sometimes the keynote speakers were too long”, “late finishes” and a “longer time for discussion”. Many commented that the experience of shortage of time was common to many conferences. Suggestions included “shorter breaks – starting and finishing earlier” as well as for “better use of time – there was a lot of ‘empty’ time then papers too crammed together”.

There was a consistent theme of the wish to use available time more effectively. Some pointed out that the “classroom and lecture theatre setup was not conducive to group discussion”. The opportunity for constructive and critical dialogue would be improved if such environmental constraints were managed more effectively, through the use of rooms and seating that enabled face to face contact between conference attendees.

The conference had three concurrent streams and a number of attendees felt constrained by the scheduling of concurrent presentations. They remarked that there were “too many presentations and not enough time for them”, “too much good stuff, too little time – maybe two streams not three” and were concerned about “having to choose between sessions – wanted to attend both at the same time but couldn’t”.

Volunteer staff and organisers received positive feedback for on-site assistance, with many comments regarding the “welcoming organisers”, “organising committee – approachable and helpful”, “friendliness and

helpfulness of organisers and volunteers on site”, “helpfulness of organisers and volunteers very good”, as well as “organisers very welcoming and easy to approach”.

### **Networking Opportunities**

The opportunity for networking was well received. The limited number and friendliness of people in attendance was seen as conducive to discussion, as a “fairly small amount of people gave us opportunity to meet more people”, “wonderful opportunity to network”, and “great opportunities for networking! The people were lovely.”

### **Supporting Organisation of the Conference Pre-conference Planning, Email Communication and Website**

Attendees generally thought well of the conference organisation, commenting, for example, that “the whole conference was professionally arranged,” and “thanks... for the hard work that must have gone into the planning. It paid off with a good smoothly-run conference”. The conference contact person received special praise, with many commenting about the “responsive help”, with others saying that her “emails were...thorough”.

Email was reported as an effective method of recruiting potential attendees, with a large majority of the survey respondents indicating they had learned about the conference either via direct email from the conference contact person, an email forwarded from a colleague, or from an email list. Receiving information via email was seen as a benefit, with “email...that included a conference timetable and a Notre Dame map was also good”. Another indicated that emails were helpful providing “guidelines for presentations and updates on the schedule”. One respondent had a different experience, indicating that it would have been “nice to receive an email that specifically stated my registration had been received and processed”.

Many commented on the efficacy of the website, in particular the online booking system and availability of useful conference information. As a positive feature, a number of attendees simply remarked “website”, and others

indicated they learned about the event online via the APS conference website. More feedback included “online registration process was fine”, “the website was informative”, “registration was clear and simple, and similarly, the website was clear and provided sufficient information”, and “the website was well resourced with the required information”.

The positive reactions were not unanimous. Some people commented that the website could have been better, specifically with regard to updating of information during the event as well as comprehensiveness of available information. One person identified as an issue the “lack of updated information about presenters on the website” and another commented “I really wish the website had been continually updated so I could develop a plan of who to see”. Another person suggested a website section separate from conference details, “allocated for just the background of keynote presenters”.

#### **Conference Brochure, Maps and Directions**

Along with the website, the brochure received both positive and negative feedback. Positive comments included “booklet was very helpful” and “brochures were informative”, “well-organised booklet”, and “program booklet very good, good scope of concise information”. One attendee remarked “I thought the little map book of Fremantle and the guide to shops/eating that was included in the registration bag was the best. Also the actual conference guide.”

Some thought that the “conference booklet could have been better organised”. One detailed suggestion was to “organise the text based on the days, not types of presentations, clearly delineating individual papers per session not just one after the other”. Another suggested “a few (blank) pages in the back... to aid in taking notes”.

Directions to the venue could have been improved. One respondent reported difficulty “initially trying to find the venue”, while another reported that they “weren’t sure where to come the first morning”. One out-of-state visitor commented on the difficulty of locating venue buildings for those unfamiliar with the area

adding that they “also knew one WA person who had trouble finding exactly where the first session was on the first day, and they were just coming from the train station”. One respondent suggested that a map beforehand would have been useful, while another suggested a “map of where to go and where to park if driving”. Signage was suggested, as the conference was held within two buildings.

#### **Conference Location and Venue**

Fremantle itself was commented on as “beautiful” and a “lovely location” for the conference. “Region was nice (Freo)” and “I think Freo facilitates these discussions better than the City (of Perth), so well picked.” The proximity of Notre Dame University to public transport was particularly well received, with “fantastic location – close to train”, “conference venue was easily accessible” and “close to shopping area... also very close to train station”.

The use of two separated University buildings received mixed feedback. One positive response was that the “venue was great and applicable to size of conference”, while another indicated that the venue “was challenging with distances between rooms requiring outdoor journey in blustery weather”. Some found “going between buildings a bit annoying”. One person suggested a “different location, with perhaps (a five star hotel) instead”. A need for “warmer temperatures in rooms” was also referred to. Several attendees suggested a venue with dedicated parking or greater provision of information on available parking nearby to the venue.

#### **Food and Catering**

Food and catering received a considerable amount of varied feedback. The welcome function was hailed as being highly successful, with comments ranging from “great venue for welcome function”, “the welcome event was a highlight – very generous provision of good food and drink, wonderful atmosphere”. The Conference Dinner was not as well received, with participants saying that they saw “the meal at the restaurant” as an opportunity for improvement. Another person commented that

the conference dinner was “way too long”. Nevertheless, the musical item provided by the Spirit of the Streets Choir was very well received. Their presentation was seen to bring home the politics of unemployment with particular effectiveness.

Turning to the tea and coffee facilities, several attendees were concerned at the perceived lack of space in the refreshment area, and the lack of seating there. They would have preferred “room with tables for meals, morning and afternoon tea”. Several respondents suggested a dispenser of pre-brewed coffee would be a good idea. Opinions on catering were highly varied: one person commented that “meals were lacking in meat” while another said there was “not enough vegetarian food”. There were predominantly positive remarks, such as “meals good”, “I really enjoyed the food”, “food was great”. One person observed that the food was “not particularly filling” and there were “usually small gourmet kind of things which didn’t help with having energy for concentrating”, while another said “fruit and nuts would have been welcome with not only cakes” at tea and coffee times. More food service points were suggested to ensure that a large number of people were provided with food and drink in the quickest point of time, and reduce the need for prolonged queuing.

### **Reflection on the Findings**

Suggestions included widening the net to include non-psychologists. Although this was done with the successful pairing of keynote speakers with practice speakers, the strategy could have been extended further. Future organisers could consider how a conference might include further opportunities for implementation. Attendees might include non-psychologists, especially politicians, their advisors, and those involved in framing State and Commonwealth government policy, in the law, and in community agencies. It may be necessary to seek such individuals out and invite them to the conference, in a similar manner to what was done for the practice speakers.

Some attendees advised that it would have

been useful to provide a clear definition of community psychology, especially as guidelines to acceptance of conference papers as some questioned whether some papers were examples of community psychology. The difficulty, however, with the question “What is community psychology?” is that such a question problematises community psychology, and in so doing allows us to become part of the problem (see, for example, Albee, 1992; Fryer & Laing, 2008). Moreover, there is the further issue of whose voice becomes dominant as to what community psychology is (Fryer & Laing, 2008).

Such issues are probably best dealt with by discussion at the conference itself, and many of the attendees wished to have more time for it, especially after keynote speakers. Although time for discussion had been intended by the organisers, keynote and practice presentations tended to take up most of the scheduled time. Future conference organisers might wish to consider a formalised discussion period in the program, and indeed potentially within every session of presented papers. Careful selection of conference venue and seating plans would also provide environmental support for discussion, aided perhaps with an opportunity for discussion circles led by individual panel members. This might provide for an active component of professional development in an activity which is often considered to be passive. Moreover, the potential use of discussion circles and their reporting could, for example, be reported as part of the updates on the conference website, and have provided material for a searching, rigorous and authoritative evaluation.

It was unfortunate that only a third of the attendees completed evaluation forms, and this low response rate limits this evaluation. Although the methodology used in this evaluation was qualitative, and so therefore does not need to meet the criteria of representativeness and generalisation, the rigour of the study would have been improved had evaluations been collected from the first session of the conference, rather than conducted on the

third and last day. Administration of the evaluation form was done traditionally (and passively) through collection of written feedback, and a more active strategy of using student volunteers to interview conference attendees throughout the conference would likely yield a higher response rate. Given that a number of participants had to leave the conference early, reminders from session chairs would also be helpful in raising the response rate. This methodological concern has potentially serious repercussions, in that the views and concerns of non-psychologists and others who are interested enough to attend part of a conference are unlikely to be represented using traditional, 'after the event' forms of evaluation as described in this report. The use of more varied and continuous evaluation processes would have improved the rigour and provided potential opportunities for challenging the status quo within our specialty.

With respect to informal discussion opportunities, networking time was well received, although many respondents indicated they would have preferred to have had seating accommodation in the refreshment area to encourage further discussion. The provision of computers within the refreshment area enabled many to catch up with their outside communications, but this tended to preclude active discussion between conference attendees.

Another suggestion made by respondents was that they would have preferred two, rather than three, concurrent sessions. As the conference is small relative to other conferences that are available, they wanted to experience many of the presentations and presenters, and scheduling three concurrent sessions reduced their opportunity to do this. Future conference organisers may wish to reconsider the format of presentation as well as or having more poster sessions to accommodate more involved discussion.

Dr. Lauren Breen was singled out as being especially helpful by conference attendees, and her work was recognised

especially with respect to email contact. The website was valued as part of the pre-conference information, although many respondents would have liked it updated during the conference. This function could be allocated to a member of the organising committee in the future.

Social highlights of the conference were the welcome function held at a local brewery in Fremantle, and the performance of the Spirit of the Streets Choir at the Conference Dinner (see their website at [www.spiritofthestreetschoir.org.au](http://www.spiritofthestreetschoir.org.au)). The location in the port city of Fremantle was well received, although accommodation across two university buildings was challenging to attendees, especially in inclement weather. Many attendees wrote that signage was needed, together with directional maps for attendees, and parking information. Alternately, conference organisers might consider a venue which is centralised, enables break out rooms and includes parking. Should university buildings be considered for a future conference, then consideration should be given to additional heating, as many attendees found the room temperatures too cold.

In conclusion, the responses indicated that the conference was successful, and the general atmosphere and themes were greatly appreciated by attendees. The conference was well received by attendees, who noted the supportive atmosphere and friendliness. The 11<sup>th</sup> Trans-Tasman Community Psychology Conference will be remembered as enabling celebration and critical reflection on the nature of community psychology and its application to both societies and individuals.

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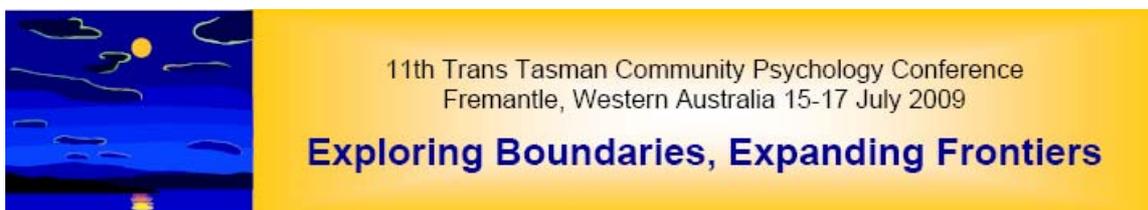
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## Appendix 1: Proforma open-ended questionnaire



### Conference Evaluation<sup>1</sup>

#### Demographic information

1. My country / state of residence

2. My ethnic identity

3. Please tick which best describes your principal role (tick as many as may apply):

Psychologist (registered/prov.reg.)     Psychologist (clinical/clin registrar)

Psychologist (other specialist title)     University staff

Student     F/T paid employment

P/T paid employment     Volunteer

Retired     Currently unemployed

4. Age (years)

Under 20     20 – 40     40 – 60     60+

5. Sex     Female     Male

6. How did you hear about the conference?

7. Why did you attend the conference?

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#### 8 Pre-conference arrangements

(e.g., brochure, registration, website, assistance from organising committee)

What worked best for you?

What worked least for you?

What one thing would you have liked to change?

**Conference arrangements**

(e.g., accommodation, meals, conference dinner, meeting rooms, time for networking, helpfulness of organisers and volunteers on site, length of conference, venue, registration fee)

What worked best for you?

What worked least for you?

What one thing would you have liked to change?

**9. Conference content**

(e.g., reflected scope of community psychology, themes of conference; social diversity issues well represented, presentations linked to social action, content represented applied settings, well organised, suited my needs, informative programme booklet, keynote speakers informative)

What worked best for you?

What worked least for you?

c) What one thing would you have liked to change?

**Overall**

(e.g., overall quality, conference content, value)

What worked best for you?

What worked least for you?

What one thing would you have liked to change?

**Additional comments:**

<sup>1</sup> Please note that we are committed to protecting your privacy. The voluntary information you give us on this form will be treated as confidential, and used to assist the organisers of future community psychology conferences.

## **Social Support Online: Benefits and Barriers to Participation in an Internet Support Group for Heart Patients**

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Paul Martin

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*The purpose of this study was to investigate if using an Internet support group for cardiac patients was associated with reduced psychosocial risk factors for heart disease and to discover why some group members became active users and others did not. The application of the Health Belief Model to determine the predictive power of participation in an online support group makes a novel contribution to community psychology, particularly because it was developed to predict health behavior. Six measures of social support/negative affect were used to determine risk reduction. One hundred and twenty (63 males, 57 females) active and inactive members of the HeartNET online community completed a survey; results indicated that the extent of participation in the group was not associated with measures of depression, anxiety, stress, perceived interpersonal support, or social network size, but was related to ratings of the perceived benefits of using the web-based forum. Specifically, participants in online peer support groups who offer and receive support may experience greater satisfaction than those who simply observe the interactions of others. This has implications for electronic health applications, as well as for researchers and practitioners, which seek to improve the lives of those who suffer from chronic disease.*

The ever increasing popularity of the Internet as an integrated aspect of people's lives has meant that its uses are being extended to all manner of applications, including healthcare. As an example of this, the renowned Pew Internet Research Institute (2005) estimated that over 36 million people had become members of online support groups in the last decade or more. In comparison to face-to-face support services, virtual groups offer privacy, convenience, and cost efficiency, which has rendered them as one of the most promising developments in the realm of electronic health (Eysenbach, Powell, Englesakis, Rizo, & Stern, 2004).

With the increasing stronghold of cardiovascular disease, cancer, and diabetes on the population, it is not surprising that the Internet has provided an environment for self-help (Madara, 1997) and risk reduction (La Corsiere, 2001) in these areas of healthcare.

While cardiovascular disease is listed as the number one cause of death globally (World Health Organization, 2009), contributing substantially to the escalating costs of healthcare (Lopez, Mathers, Ezzati, Jamison, & Murray, 2006), social support has not been adequately verified as an effective strategy for cardiovascular risk reduction. Given depression, anxiety, and social isolation are identified by the National Heart Foundation (2003) and other well respected researchers (Bunker et al., 2003; Ormel et al., 2007) as the most pertinent to cardiac risk, there is a need to establish what role social support groups play, particularly in the online setting, in the reduction of these. One study has provided some evidence of a reduction in psychosocial risk for heart patients in the context of an online community, HeartNET. This research demonstrated that the social support provided by online peers minimised the negative experience of heart

disease (Bonniface, Green, & Swanson, 2005) and provided adaptation strategies for the health-promoting acceptance of heart conditions (Green, Bonniface, & McMahon, 2007). While the HeartNET study has been the subject of an in-depth qualitative research agenda since its inception in 2004, this current study seeks to verify and quantify to what extent the social support provided by peers in the HeartNET setting reduces psychosocial risk factors for heart disease. This is an important contribution to the field of community psychology, particularly if peer-to-peer social support groups are to be taken seriously in the ever expanding area of electronic health, and so that researchers and practitioners might leverage their success for other health promoting purposes.

#### *The Role of Peer Support in Cardiac Rehabilitation*

Peer support groups are usually described by members as beneficial and while their widespread popularity is testament to this, relatively few studies have substantiated the outcomes of such groups. To explore the effects of one-on-one peer support for cardiac patients, Parent and Fortin (2000) conducted a randomised, controlled trial in which 27 patients awaiting a coronary bypass graft were visited by a former patient 24 hours prior to surgery on the fifth post-operative day and four weeks after discharge. These former patients provided the experimental group with 'living proof' of a successful surgery and rehabilitation, listened and responded to concerns, reinforced the need for healthy behaviours, encouraged physical activity, and provided other emotional or informational support tailored to individual patient needs. The control group received standard medical information and care. Although the experimental group had higher anxiety scores at baseline, their anxiety level dropped after the first visit from a former patient and remained lower than that of the control group at five days and four weeks post surgery. The experimental group also reported higher levels of self-efficacy and physical activity at discharge than the control group, suggesting that peers can support

recovery from heart surgery. Even though the peers in their study underwent training before offering support, it is possible that these benefits might also translate to more natural community settings, including the online setting, particularly if the true value of the support provided is by virtue of the experience shared by former patients.

As a broader strategy for risk reduction in cardiac care, cardiac rehabilitation programs are made widely available to Australian heart patients. However, it is reported that only 24% of heart patients take advantage of these programs despite the fact that the mortality rates for those who do attend reduce significantly (Sundararajan, Bunker, Begg, Marshall, & McBurney, 2004). This may be due to the opportunity for social support that rehabilitation programs provide; although this is missed for the majority.

In Sweden, all cardiac patients are invited to participate in peer support groups for exercise, diet, stress management, and smoking cessation as part of a program offered by the Heart and Lung School. Hildingh and Fridlund (2003) investigated the outcomes of this program over a period of three years and found attendees reported denser social networks and higher levels of social support than controls at both 12 months and three years. Although physical health outcomes were similar between groups, 71% of attendees also reported physical activity several times per week compared with 40% of controls, and only 6% smoked compared with 20% of the control group. As there were no significant differences between groups at baseline, results may be attributed to program participation (Hildingh & Fridlund, 2004). However, the experimental group in this study was self-selected and attended different activities over varying periods of time, meaning that randomisation and control was not achievable. Thus, the variation within groups and interventions limits the generalisability of the research, though it may also more accurately reflect the variable uptake and effect of peer support interventions in the community.

The poor rehabilitation attendance noted in Australia may be partly reflected in patients' general dislike for group formats (Farley, Wade, & Birchmore, 2003); this calls for alternative strategies to achieve risk reduction and the secondary prevention of heart disease (Jelinek, 2004). However, more recent studies (e.g., Fernandez, Salamonson, Juergens, Griffiths, & Davidson, 2007) suggest that traditional cardiac rehabilitation, and their low attendance, remains the norm. Therefore, the provision of online social support as an alternative strategy may provide a more comfortable (anonymous) group format to satisfy patients who are uncomfortable with traditional group formats and may ultimately boost participation.

#### *Health-related Peer Support on the Internet*

Given the convenience and cost efficiency of social networking online, it is unsurprising that crude Internet searches produce thousands of 'hits' for support groups making them easily accessible; although, digital inclusion is a matter of having access to computers and knowing how to use them (Willson, 2006). As with the traditional face-to-face formats, online support groups are often facilitated by peers and are frequently health related (Coile, 2000). For cancer support online, thematic analyses have indicated that both male and female cancer patients are primarily concerned with the emotional and informational support offered by their peers online (Blank & Adams-Blodnieks, 2007; Gooden & Winefield, 2007). What is more, participants in these groups may also seek to provide this support.

After analysing messages sent by members of an online cancer support group, Winefield (2006) interviewed two correspondents who wrote approximately twice as many posts as the average user, the majority of which were supportive rather than support seeking. Both indicated they had gained emotional satisfaction from their role as 'volunteer emotion workers' and from feeling they had done something valuable for someone else. In the comprehensive HeartNET study mentioned earlier, the researchers reported that "the self-help element

of the support site is triggered through helping others, and reciprocal impulses mean that where a member joins the site in order to get help they may then stay involved in order to offer it (Bonniface & Green, 2007a).

A review of 100 face-to-face social support groups similarly suggested that engaging in reciprocal (peer-to-peer) support may be more efficacious than simply receiving support (Hogan, Linden, & Najarian, 2002), as observed in an investigation of support groups for stress, overeating and multiple sclerosis (Maton, 1988). In this earlier study, participants who provided or received support reported less favourable wellbeing and group appraisal than members who did both. Thus, giving support may be as potent a motivator as receiving support for members who continue to participate in groups online or in person, perhaps because of the 'ego boost' this provides, a dynamic which has previously been referred to as a gift economy (Raymond, 2000) and one which occurred on the HeartNET website (Bonniface & Green, 2007a).

To quantify the reported benefits of online support for people with medical conditions, Lieberman and Goldstein (2005) asked 114 women from five breast cancer bulletin boards to complete measures of depression and quality of life upon joining the groups and six months later. A repeated measures analysis of variance showed scores on the Centre for Epidemiological Study Depression Scale (CES-D) were improved at follow-up ( $F [1, 90] = 10.54, p = .002$ ) and that changes interacted with duration of group participation ( $F [1, 90] = 10.28, p = .002$ ). Interestingly, the largest decrease in CES-D scores was observed in those who participated for less than two months, with many stating their needs had been fulfilled before the end of the six month study. Increases in quality of life measures were not significant. Overall, the authors concluded that group participation had positive psychosocial outcomes for members, particularly those who were clinically depressed at baseline. In contrast to the cross-sectional design often used in

online group research, the strength of this study was the collection of baseline data for new members before they were exposed to the group, which is often not possible when studying existing support groups. However, the absence of a control group means that depression symptoms may have resolved over time; whether members experienced faster or greater improvements in their psychosocial wellbeing as a result of participating in the groups remains unclear.

#### *Active Participation and Emotional Relief*

Consistent with the findings of Lieberman and Goldstein (2005), measurable improvements in emotional wellbeing have been observed in a one year prospective cohort study of Internet support groups for depression. With the dual aims of describing user characteristics and assessing change in depression symptoms and social support over time, Houston, Cooper and Ford (2002) administered the Medical Outcomes Study (MOS) Social Support Survey and CES-D to 103 support group members at baseline and 12 months later. Participants came from North America, Australia and Europe; 78.6% were female and 82.6% were tertiary educated. Contrary to fears that the anonymity of online groups may encourage deception or inappropriate use (Lamberg, 2003), results showed 86.4% of users were currently depressed (CES-D scale score >22) and the remaining members had previously received a diagnosis of depression. Participants also had low levels of tangible, affectionate and emotional support as baseline, making their participation in the group an appropriate choice for both their depression and social isolation. While social support scores remained unchanged at follow-up, depression had resolved (CES-D scale score <22) in 33.8% of individuals with depression at baseline. Over 95% of participants believed chatting on the Internet helped their symptoms and 37.9% preferred this to traditional counseling, although 81% were still receiving face-to-face care, which may indicate that online support in

this capacity is a useful adjunct or is an important element of a more cohesive treatment regime. Emotional support was the most popular reason to use the group, followed by the support which comes through the sharing of information (informational support). Over 50% of participants were frequent users of the support group (five or more hours a fortnight) and 72.6% were still participating after 12 months. Interestingly, depression resolved in 42.9% of frequent users, compared with 20.7% in those who used the group less than five times per fortnight. This relationship remained significant after adjustment for age, gender and baseline CES-D scores. In sum, participants with depression believed they experienced considerable benefit from the Internet support group and higher levels of participation were associated with a greater resolution of depression symptoms over time.

In the previous study of breast cancer bulletin boards, 77% of participants delayed their participation for a period of time before posting (Lieberman & Goldstein, 2005) – usually referred to as ‘lurking’ – perhaps by taking the time to read the posts made by others before authenticating themselves through visible text. As there is some evidence that passive readers far outnumber active participants in online discussion groups (Zrebiec & Jacobsen, 2001), the authors suggested that there may be a therapeutic benefit in simply reading posts and that the outcomes of passive participation or ‘lurking’ should be more closely examined.

Though this has not previously been the subject of empirical research, the relationship between activity level and emotional relief has been investigated by Israeli researchers Barak and Dolev-Cohen (2006), who analysed 790 messages posted by 20 randomly selected members of an online support group for suicidal and severely distressed adolescents. Each message was given a ‘distress rating’ by three specially trained adjudicators and an analysis of variance was carried out using the total distress scores for each participant. Although the

emotional distress of the group did not decrease over the three-month period of participation, members who posted and received more messages during the first month expressed lower levels of distress in the following two months. The authors concluded that online support groups may often have little effect on average, yet significantly benefit certain individuals. More specifically, positive outcomes are most likely to be experienced by those who have the highest level of active participation in the group. As passive participants were excluded from this study, the experience of the lurkers remains unknown and it is possible that the distress of some participants was significantly worse after joining the group rather than better. However, the converse relationship between active involvement and later distress is consistent with previous findings that support group members who give *and* receive support experience greater satisfaction than those who do either or neither. Lurkers may therefore experience less benefit from online support than those actively involved.

#### *Online Support for Heart Patients*

Cardiac patients have been the recipients of various electronic health services including specialist consultations via videolink (Sekar & Vilvanathan, 2007), monitoring of electrocardiogram results transmitted from mobile phones to hospital databases (Salvador et al., 2005), web-based education for patients awaiting surgery (Scherrer-Bannerman et al., 2000) and the creation of purpose-built online peer support groups (Bonniface et al., 2006). While HeartNET is perhaps the best Australian example of the growing evidence for online peer-to-peer social support, with psychosocial and behavioural outcomes pending publication, online social support interventions, generally, are notable for the lack of empirical evidence underlying their widespread use and popularity. The HeartNET online community was created to provide heart patients with opportunities to share experiences with others facing similar circumstances, to offer mutual support, and to access this support from rural or remote regions. The group was initially designed as a member's

only (closed) website available only to research recruits from a specific demographic and regional area. This design proved unsuccessful in the early stages, primarily because there were insufficient numbers to create ongoing communication exchanges; for those who did engage, they soon lost interest and participation ceased altogether by the eleventh week of the trial (Green et al., 2007).

Due to the failure of the first HeartNET site, the randomised-controlled design was suspended and HeartNET was opened to the public. The group subsequently became popular amongst people from a range of locations, age-groups and backgrounds, supporting the notion that meaningful social connections cannot easily be orchestrated in research trials. In the main, this may be due to the extremely large samples needed to capture the 'natural' aspects of selection and engagement in online groups, which include negative as well as positive interactions. In fact, disputes between HeartNET members did occur, perhaps because it was more representative of real life rather than a controlled research setting, yet the potential for positive experiences appeared to outweigh the risk of conflict (Bonniface & Green, 2007b). Analysis of discussion board posts and interviews with participants indicated that the group had rallied together in spite of the conflict and continued to provide the emotional support which had been evident beforehand (Green & Costello, 2009). Many posts addressed the fear, anger or distress experienced by members in relation to cardiac disease and it was concluded that the prospect of reducing negative emotions contributed considerably to the success of the group (Bonniface et al., 2005). The site also created opportunities for newly diagnosed heart patients to redefine their sense of self in light of their medical condition (Green et al., 2007) and to assess health-related information found online in a supportive environment, with the assistance of other members (Bonniface & Green, 2007a). Furthermore, HeartNET members initiated their own system for reporting their exercise

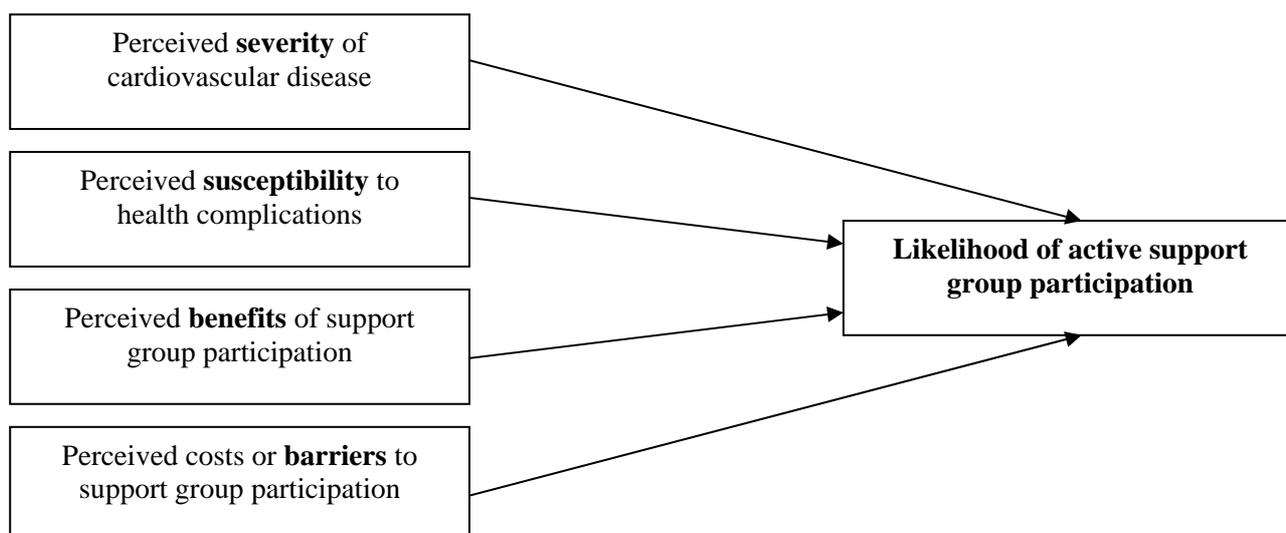


Figure 1. Health Belief Model.

achievements and encouraging the physical activities of their peers (Bonniface, Omari, & Swanson, 2006). Thus, the group facilitated multiple aspects of cardiac rehabilitation by providing emotional and informational support and promoting physical fitness after cardiac events.

#### *Predicting Health-Related Behaviour*

As greater participation in online peer support has been linked to reduced levels of depression and emotional distress, predicting which group members are likely to become active participants may assist in the referral of appropriate individuals to support groups and increase their efficacy. The Health Belief Model (HBM) has been used to explain variations in health behaviour among coronary heart disease patients in the past (Ali, 2002) and may also serve as a framework for the prediction of participation in online support groups for cardiac patients, if we consider this a health supporting action purposefully undertaken by members to enhance their physical and mental wellbeing.

The HBM posits that the likelihood of performing a health behaviour is determined by perceptions of susceptibility to and severity of the health condition, coupled with an analysis of the benefits and barriers to performing the health

promoting action. Figure 1 illustrates the HBM as it was applied in the current research project. Considering the literature reviewed here provides some evidence of the positive outcomes of support groups for people with cardiac disease, this study examined: 1) the relationship between participating in an online support group and psychosocial risk factors, and 2) reasons for active group participation.

#### *Method*

##### *Participants*

With permission from the HeartNET team of researchers, a total of 203 active members and 516 inactive members of the HeartNET online community were invited to participate, with response rates of 28% and 12% respectively. Sixty-three male (63) and 57 HeartNET members, aged between 22 and 79 years ( $M = 53.73$ ,  $SD = 11.88$ ), participated in this study. Fifty-seven participants had posted messages on HeartNET discussion boards and were thus classified as active Members. The sixty-three inactive participants included those who either never logged on to the website after their initial visit or had not posted any messages on the discussion boards after logging on (therefore, including those who may have 'lurked' the site). Eighty-eight percent of

participants were heart patients and the remaining 12% were carers, family members or friends of someone with a heart condition. Heart patients were diagnosed up to 52 years prior ( $M = 8.65$ ,  $SD = 10.35$ ) and all participants had been members of HeartNET for between 1 and 208 weeks ( $M = 127.13$ ,  $SD = 60.64$ ). The majority of participants had a tertiary education (69%), lived in urban areas (68%), and were married or living with a partner (76%). They had between 2 and 35 years ( $M = 15.91$ ,  $SD = 7.40$ ) experience using computers and had a home or work computer connected to the Internet for at least 3 years ( $M = 11.10$ ,  $SD = 4.46$ ).

#### Measures

An online survey was constructed incorporating six established measures of negative affect and social support, as well as a 38-item questionnaire based on the HBM. The questionnaire addressed the benefits and barriers to HeartNET membership, health-related perceptions, and demographic information. The first two predictors posited by the HBM, perceived severity of the heart condition and susceptibility to health complications, were rated on a scale from 1 to 10, where 1 was 'Not Severe' and 10 was 'Extremely Severe'. The remaining two predictors, perceived benefits and barriers to participating in the HeartNET group, were assessed using 26 statements, which were rated on a 5-point scale. Ratings were summed to produce a total benefit and barrier score for each participant, with higher scores reflecting a greater importance of those factors to the individual.

The other six measures included in the survey, which have all achieved good reliability and validity scores in verifying studies, were: 1) *The Depression, Anxiety and Stress Scales* (DASS; Lovibond & Lovibond, 1995); 2) *The ESSI Instrument - Enhancing Recovery in Coronary Heart Disease Patients (ENRICH)* *Social Support Instrument* (Vaglio et al., 2004); 3) *The Interpersonal Support Evaluation List* (ISEL; Cohen, Mermelstein, Kamarck, & Hoberman, 1985); 4) *The Social Connections Index* (SCI; Kaplan, Salonen, Cohen, Brand,

Syme, & Psuka, 1988); 5) *The Social Networks Questionnaire* (SNQ; Glass, Mendes de Leon, Seeman, & Berkman, 1997); and 6) *The Perceived Social Support Scale* (PSSS; Dahlem, Zimet, & Walker, 1991).

#### Procedure

Participants in the broader HeartNET study were initially recruited through local cardiology clinics and through databases kept by National Heart Foundation of Australia (WA). Recruitment was promoted via word of mouth, Internet browser listings, poster advertisements in medical centres, and articles in newspapers and in magazines. Members give consent upon registering with the HeartNET group for their website activity to be logged and for this information to be used for research purposes. A reminder to review terms and conditions is also presented each time a member logs on to the website.

With support from the HeartNET researchers and web developers, 719 members of the website were invited via email to complete the online survey for the current investigation. An invitation to participate was also posted on the website discussion board and two reminders were emailed to members who had not yet completed the survey during the two months of data collection. In addition to asynchronous discussion boards which allow members to leave public messages on a range of different topics for the group to 'discuss', the HeartNET website also features a chat room, private messaging system, and informational resources related to heart disease. However, as the discussion boards are the most popular aspect of the site, the number of discussion board posts contributed by each member was gathered from the existing HeartNET database and was used to determine if participants were active or inactive members. Consent and contact details were collected through an independent webpage and participants were matched with survey responses using unique correlation codes in order to ensure anonymity. The median response time taken to complete the survey

Table 1

*Mean DASS, ESSI, ISEL, PSSS, SCI and SNQ Scores as a Function of Support Group Participation Level*

	Active Members ( <i>n</i> = 40)	Inactive Members ( <i>n</i> = 34)	Total ( <i>n</i> = 74)
DASS	25 (24.4)	30 (26.3)	28 (25.4)
ESSI	17 (5.8)	15 (6.2)	16 (6.0)
ISEL	124 (23.4)	117 (24.5)	120 (24.0)
PSSS	67 (14.1)	64 (15.2)	66 (14.7)
SCI	15 (4.1)	15 (3.7)	15 (3.9)
SNQ	36 (20.9)	30 (15.3)	34 (18.6)

Note: Standard deviations are presented in parentheses.

was 22 minutes. Responses were not compulsory and participants were therefore free to skip questions at their discretion.

### Results

The mean and standard deviation of scores on the DASS, ESSI, ISEL, PSSS, SCI and SNQ for active and inactive members of HeartNET are presented in Table 1. A multivariate analysis of variance (MANOVA) was undertaken to explore the relationship between negative affect, social support, and active participation in the group. Composite test scores for the DASS, ISEL and PSSS were used to increase the power of analyses. The variance-covariance matrices were homogeneous, Box's  $M = 29.366$ ,  $F(21, 18010) = 1.27$ ,  $p = .181$ , and hence Wilks' Lambda was used. Results of the MANOVA, contained in Table 2, showed participation in the group was not related to measures of negative affect or social support,  $F(6,67) = .97$ ,  $p = .930$ . As emotional status has been found to improve most during the first few months of participation

in online support groups (Lieberman & Goldstein, 2005), data were examined to assess if duration of membership could be included as a factor in post hoc tests. Only six participants were identified as being new members who had joined the group less than three months earlier and this small sample was therefore not suitable for further analysis.

A logistic regression was conducted to ascertain whether demographic variables and HBM predictors were related to HeartNET participation. As shown in Table 3, active members of the support group tended to rate the benefits of participation as more important and barriers as less important than inactive members, after controlling for age, gender, location, level of education, computer literacy, perceived severity of their illness and perceived susceptibility to health complications. None of the other predictors achieved significance.

Table 2  
*F Ratios for Univariate Main Effects of Negative Affect and Social Support on Support Group Participation Level*

	<i>df</i>	<i>F</i>	<i>P</i>
DASS	1	.93	.34
ESSI	1	.69	.41
ISEL	1	1.02	.31
PSSS	1	.46	.50
SCI	1	.48	.49
SNQ	1	1.06	.32

Table 3  
*Beta, Standard Error and Wald Values for Age, Gender, Location, Education, Computer Use, and HBM Predictors in Active and Inactive Members*

	<i>B</i>	Standard error	Wald
Age	-.01	.02	.08
Gender	-.10	.50	.04
Location	-.05	.50	.01
Education	.15	.24	.40
Computer Use	-.06	.04	2.79
Severity	-.09	.13	.46
Susceptibility	.01	.13	.01
Benefits	-.09	.03	7.03*
Barriers	.11	.04	6.99*
Constant	2.74	2.75	1.00

\*  $p < 0.05$

NB:  $\chi^2 (9, N = 87) = 21.51, p < 0.05$

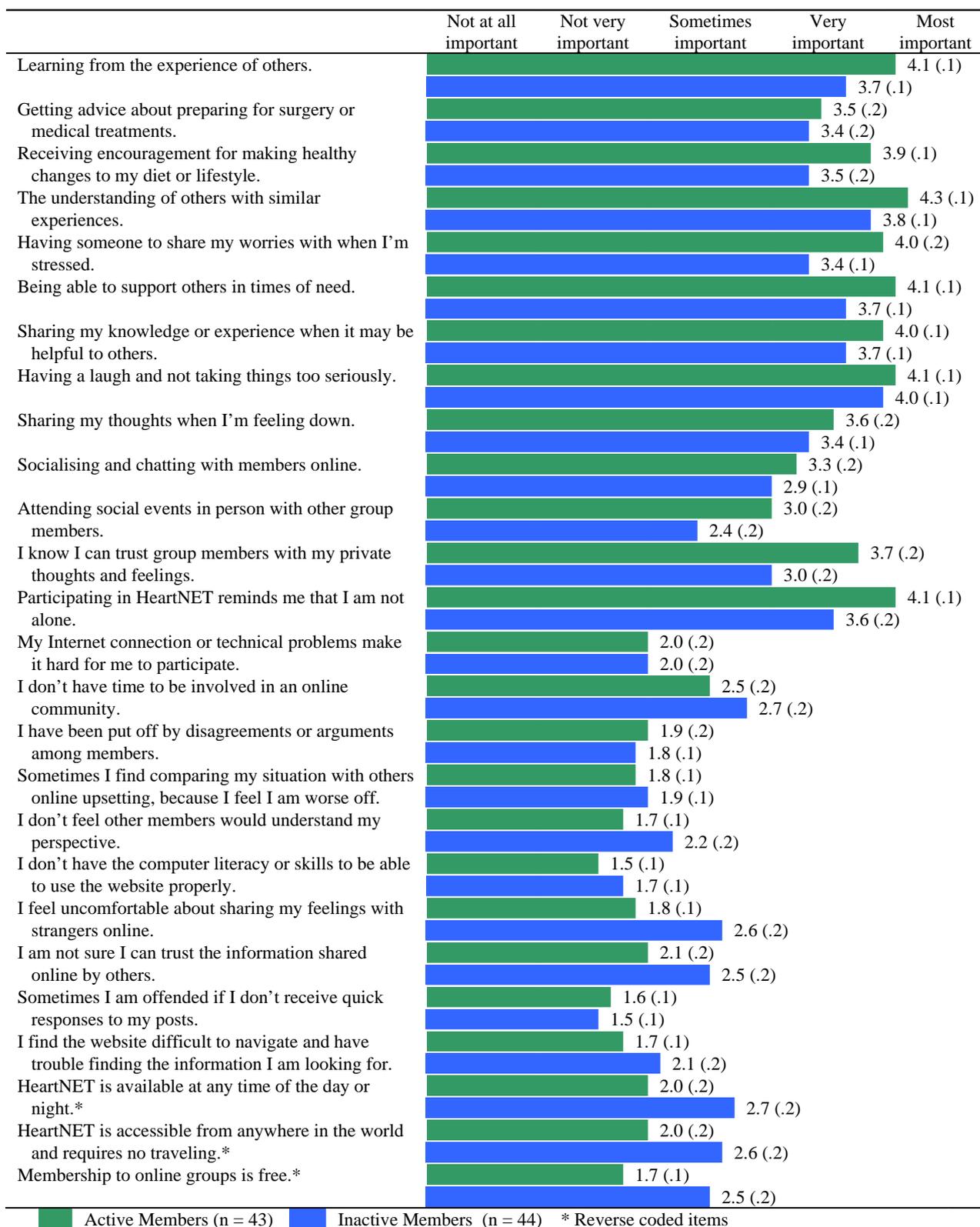


Figure 2. Mean ratings of benefits and barriers to support group participation for Active and Inactive Members (Standard deviations are presented in parentheses).

All benefits of HeartNET membership were rated as important by over 75% of participants, except 'attending social events in person with other group members', which was rated as important by only 59% of participants. The highest rated benefit was 'learning from the experience of others', with 98% of participants indicating this was important. Figure 2 presents mean ratings of benefits and barriers to HeartNET participation by active and inactive members.

### Discussion

The hypothesis that active participation in an online peer support group for cardiac patients would be associated with reduced psychosocial risk factors for heart disease was not supported by this study. Members who posted messages on the discussion boards did not have significantly lower levels of negative affect than those who were classified as inactive members and participation in the group was not related to current symptoms of depression, anxiety, and stress. However, unpublished doctoral research (Costello, 2009) conducted by a member of the HeartNET research team does provide detailed interpretive evidence to the contrary, possibly pointing to the value of qualitative research in revealing the finer details not exposed through this quantitative approach. Although the results of this study are inconsistent with qualitative findings and the observed relationship between activity level in online support groups and measures of depression (Houston et al., 2002) and emotional distress (Barak & Dolev-Cohen, 2006), variations in duration of group membership may partly explain this discrepancy. Participants in the current study had been members of the support group for up to four years before data collection, while participants in these previous studies had provided baseline data or were followed for a period of only three months. Furthermore, Lieberman and Goldstein (2005) found women who contributed to breast cancer bulletin boards for one to two months had greater decreases in their depression scores than those who participated for three to six

months. It is therefore possible that active participants in the current study experienced similar changes in their emotional status after first joining the group and that these effects dissipated over time. Still, Gustafson et al. (1999) asserted previously that for individuals who were isolated, benefits could be delivered, regardless of time – when they needed it most – even if those benefits were not maintained over the longer term. Although these authors recognised that while the maintaining of benefits is ideal, delivering any 'amount' of benefit, particularly for those who cannot access support easily, is a worthwhile outcome.

In addition to equal levels of negative affect, active and inactive members of the online support group had equivalent levels of perceived social support and similarly sized social networks. However, as users were not required to log on to read discussion board posts, we cannot be sure how many inactive members might have been 'lurking' the site and it is possible that these lurkers gained social support by reading the posts of others. Considering both groups had comparable social resources available to them, lower levels of perceived support from family and friends did not appear to promote greater activity or reliance on the support group. Again, the interpretive research already conducted with HeartNET might add some explanation here, in that heart patients, generally, do not necessarily see their family and friends as being capable of providing good support because of their inability to truly understand experiences (Costello, 2009).

Given that established social support measures tend to focus on face-to-face interpersonal contact, rather than online communication and connectedness, there were some indications by participants that the questionnaire did not assess the contribution virtual interactions made to their social lives. For example, one participant who had frequent 'chats' with family members living interstate or overseas commented that 'not having tangible contact doesn't necessarily cause loneliness, as seems to be implied in your survey.' Further to this, 'attending social events in person with other

group members' was the lowest rated benefit of HeartNET membership, suggesting that participants were generally not seeking to expand their face-to-face social interactions. Users of social networking websites might therefore consider their virtual communications to be a completely different but no less a valuable source of support, not wholly captured by the measures employed in this study. If this is the case, future research may benefit from using an instrument specifically designed to assess online peer-to-peer social support, provided a valid and reliable tool becomes available. However, social events were not available to many HeartNET members due to logistical challenges and these members have expressed a desire for face-to-face connectivity with their online peers (Bonniface & Green, 2007b; Green & Costello, 2009). More in-depth interpretive research is therefore needed to fully explore the relationship between online and face-to-face interactions of support group members and bring to light the meanings and outcomes associated with this modality.

#### *Benefits of HeartNET Participation*

The assumption that the HBM could be used to predict extent of participation in the online community was partially confirmed by the finding that active members considered the benefits of the group to be more important, and barriers to be less important, than inactive members. Active participation in the peer support group may therefore have led to greater satisfaction, as was found in previous studies by Winefield (2006) and Maton (1988). Conversely, more positive appraisals of the group may have led to greater participation. In either case, the perceived severity of cardiac disease and susceptibility to health complications of members did not predict level of participation, suggesting that the predictive power of the HBM in this context is limited. Other models of health behaviour, such as the Transtheoretical Model (Prochaska et al., 1994), may offer greater predictive power and could be investigated in future, particularly in relation to the stages heart patients might need to move through before they

are ready to take up membership in online support settings. While the majority of respondents to the survey were tertiary educated and lived in urban areas, this is likely to reflect the attributes of Internet users generally and demographic variables were unrelated to level of support or group participation. Thus, the group seems to appeal to a diverse range of people and it would be inadvisable to base referral of new members on the characteristics examined. Furthermore, the number of male and female participants in this study was approximately equal, suggesting a similar willingness of each gender to seek and contribute to this peer support group.

Although the cost-benefit analyses of active members were more favourable, inactive members of the HeartNET site rated 10 of the 13 benefits of membership as very important aspects of the group. These included learning from the experience of others, getting advice, being understood, receiving encouragement, sharing worries, being able to offer support, helping others, having a laugh, socialising, sharing thoughts when feeling down and feeling less alone. As the benefits of participation received high ratings from both groups, even members who were classified as inactive appeared to appreciate what the group had to offer and viewed the service as valuable. This suggests that there may have been a substantial number of lurkers in the inactive sample and that they do derive some social support from reading posts rather than actively participating. Any therapeutic effect experienced by active members as a result of these benefits might therefore be experienced to a lesser extent by lurkers and this relationship warrants further investigation. In this respect, the role that health workers or moderators of online groups have in converting inactive participants to active participants is highlighted. Therefore, there remains a need for further research to determine the level of engagement needed to encourage broader participation.

#### *Methodological Challenges and Limitations*

Peer support groups are necessarily not

standardised interventions. Participants select themselves and attend intermittently over varying periods of time. The flexibility of these therapeutic communities can allow effective responses to the unique social, emotional and informational needs of individuals and attempts to replicate this in researcher-controlled environments are unlikely to be successful because of the difficulty in replicating the 'natural' setting. The ability of participants to initiate their own membership and pattern of involvement may therefore be vital to the success of such services. For these reasons, the present study utilised an existing online community to explore the relationship between level of group participation, psychosocial risk factors for heart disease and a range of predictor variables. Although this ensured a more naturalistic research setting, many limitations common to investigations of peer support efficacy remained, including the absence of an appropriate control group, a lack of opportunity to collect baseline data, and a restricted sample size. Despite approximately equal numbers of active and inactive members participating in the study, the response rate of active members was, not surprisingly, more than double that of inactive members, which may have biased outcomes. Inconsistent definitions of social support throughout the psychological literature also resulted in a need to use multiple measures of this construct and increased response burden on participants, which may have led to incomplete survey responses.

At the time of data collection the HeartNET group had over 700 members, yet the response rate to the survey was low. However, the reviewed evaluations of breast cancer bulletins boards (Lieberman & Goldstein, 2005) and online emotional support (Barak & Dolev-Cohen, 2006; Houston et al., 2002) had smaller samples than the present study, despite recruiting from many different support groups. In the area of face-to-face peer support for heart patients, the randomised-controlled trial conducted by Parent and Fortin (2000) had a sample of only 27 males and 125 of the 160 participants recruited

by Hildingh and Fridlund (2003) did not attend a peer support intervention, even though every heart patient in Sweden had been invited to participate in the program they evaluated. As such, the problem of small sample size is not unique to this study. Given that peer support group evaluations are observational, larger samples are required and could be achieved by pooling data across studies.

### *Conclusions*

The results of the present study indicate that active participation in an online support group for heart patients is associated with greater perceived benefits than simply observing the interactions of others. This is consistent with previous findings that support group members who give *and* receive support experience greater satisfaction than those who do one or the other. Members indicated that 'learning from the experience of others' was the most important benefit of group participation, the value of which has been examined in earlier publications by the HeartNET research team (Bonniface & Green, 2007a). Benefits of membership received high ratings from both active and inactive members, suggesting that any effects of active participation might be conferred, albeit less efficiently, by passively reading discussion board posts. As demographic variables did not differ between the two groups, referral of cardiac patients by healthcare professionals based on these characteristics would not be recommended. The hypothesis that active participation would be associated with reduced negative affectivity and social isolation was not supported by this study, despite the widely held belief among participants that the group provided valuable emotional support. Although it is possible that participants experienced changes in emotional status during the initial months of their membership, causal relationships between support group participation and reduced negative affect are difficult to determine through observational studies. The cyclical nature of depressive symptoms over time must therefore be considered as an explanation for

both the findings of the current study and those of previous researchers; even so, these benefits are commendable and applicable. Given that the dynamic social aspects of online peer support groups cannot be easily replicated in randomised-controlled trials and that the popularity of these groups continues to grow, larger longitudinal studies using baseline data and in-depth interpretive research are required to investigate if these groups have measurable effects on cardiovascular risk. If this can be achieved, the dynamics of online social support groups may be better utilised by various health professionals in order to reduce the burden of disease and enhance the health of those who adopt their membership.

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*Psychology and Indigenous Australians: Foundations of Cultural Competence.* Rob Ranzijn, Keith McConnochie and Wendy Nolan, 2009

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Over a decade ago, the then-APS Accreditation Guidelines set the requirement that Indigenous and intercultural psychology be taught at introductory and subsequent levels in the three year undergraduate psychology program. In the current APAC Accreditation Standards, Graduate Attribute 1, Core knowledge and understanding, requires that students demonstrate an understanding of, *inter alia*, intercultural diversity and Indigenous psychology. When asking universities about how they meet this Standard, site visit teams are invariably told that some coverage is given but a claimed lack of knowledge on the part of lecturers and the lack of a suitable text to assist students' learning are cited as impediments.

The publication of this book goes a considerable way to meeting these needs. While there have been previous books such as those by Dudgeon, Garvey and Pickett (2000) and more recently, by Purdie, Dudgeon and Walker (2010), where the focus has been specifically on the practice of psychology with Indigenous populations, the current monograph provides much wider and richer historical and contextual information about Indigenous culture and how this influences and is influenced by psychology.

Clearly there needs to be further development in psychological relationships with Indigenous populations and greater general recognition of past injustices and how these affect the cultural perceptions held about the role of professional assistance. Practitioners need to be sure they are familiar with Indigenous values and behaviours, and in these times of increased immigration (including refugees) from African and Asian countries, there needs to be greater awareness of cultural differences and expectations. Training psychologists in cultural

awareness, sensitivity and being non-judgemental is fundamental and this textbook provides a starting point for the development of such cultural competence. Cultural competence refers to a set of skills and understandings that enable professionals to move outside their own cultural views and limitations to engage more widely in a range of cultural contexts. With this in mind, the book aims to develop a new generation of psychologists who can work appropriately and effectively with Indigenous clients and communities. This is indeed a brave and welcome step forward.

But while ultimately the book focuses on ways of working more sensitively with Indigenous people and communities, it is the earlier chapters that provide the historical context to colonisation mainly by Westerners from Europe. The authors provide descriptions of Indigenous societies and how they operated, the importance of the Dreaming and of social and kinship organisations. The areas that are important to Indigenous cultural history are:

- connections to land and country;
- the significance of sacred sites and stories;
- creation – the Dreaming, a timeless dimension at the dawn of time;
- the importance of kinship and family; sharing and reciprocity, as values in Aboriginal life;
- living a traditional egalitarian lifestyle; and
- the role of death, grieving and funeral practices.

All of these represent traditional cultural values and behaviours which carry some relevance into twenty first century Australian culture and, it is argued, need to be respected in our multicultural society alongside the values and practices of the immigrants.

Special mention is also given to the Stolen Generations (in the plural) which refers to the forced separation of children from their families from the late 1800s until the 1960s. These separations were part of the Government policy of assimilation to help the children

become more like white children. Three kinds of separation occurred: placing Aboriginal children into government-run institutions, white families adopting Aboriginal children and Aboriginal children being fostered by white families. In 1997, the Human Rights and Equal Opportunity Commission released *Bringing them home*, the personal experiences of many Indigenous people removed from their families. The authors rightly point to the devastating effects that continue to this day of such forced removals of children.

One aspect of the book that teachers will find useful is the influence that psychology and psychologists have had on the way Indigenous peoples are described and on the provision of information that influenced government policies (Chapter 11). From my perspective, much of the work on IQ testing and children's cognitive development influenced the type and delivery of educational programs to Indigenous children. So, for example, the finding that Indigenous children did not perform as well on Piagetian tasks led to compensatory educational programs to assist with the apparent deficit in their abilities.

While this book fills an obvious gap in the resources available for the teaching of Indigenous psychology, it is not without some flaws. The writing at times is uneven with some long sentences, grammatical inaccuracies, inconsistencies in style (almost inevitable with three different authors) and level of writing, plus some clumsy wording. It is also not at all clear to what level of student the book is directed. As some universities move to more generic units at first year, then topics such as Indigenous psychology might find their niche in broader cultural awareness classes. It could also be argued that the information in the book would be best targeted at students in, say, third year, when they can place the information in a broader context and are perhaps thinking about a career in applied psychology. It would have been helpful if the authors had indicated their intended student

audience and their writing the pitched to that particular level. As it is, in some places the writing and the exercises seem to be things that primary school students might do (for example, exercise 9.2) while other topics and writing are highly sophisticated (such as concepts like 'invisible privilege' and the moral and political complexities around the removal of children). These are minor quibbles and I hope that the book will be found to be useful resource and a starting point for teachers to read more widely and to think about Indigenous peoples, their culture, their history and the skills psychologists need to work with them effectively and competently.

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Shaw, L., Tacconelli, E., Watson, R. & Herbert, C. (2010). *Living confidently with HIV: A self-help book for people living with HIV*. Blue Stallion Publications: Oxfordshire UK. ISBN: 97819041217093. 269 pages.

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In a world where more than 25 million people have already died of AIDS and over 34 million are HIV positive, the issue of learning to live well with HIV is pertinent to every nation. The increasingly prevalent use of rape as a weapon of war has caused additional HIV infection and burden. Globally, women represent the majority of those infected with HIV (in war torn countries this rate rises to as high as 70% of prevalence) and approximately half a million children are infected with HIV annually. There are already over 14 million children in Africa who have been orphaned by HIV. Thus the title, “Living confidently with HIV” was one which held much promise. I have worked for many years with HIV education, both as a sexuality educator and as the co-facilitator of an International HIV Monitoring and Evaluation course run six monthly through International Health. This course was delivered primarily to government and health officials responsible, in their respective nations, for the monitoring and evaluation of HIV infection and treatment.

The book has a UK base and focus. It begins with some optimistic statements and aims – “The introduction of new drug therapies for HIV infection (combination therapies) means that it no longer needs to be seen as a “death sentence”, but as an infection that can be controlled in the long-term, similar to diabetes or high blood pressure” (p. 14). The book also begins by declaring that the type of chronic disease that one has is not the strongest predictor of wellbeing but that more important areas include, “having a supportive partner and friends, good self-esteem, a job or occupation that you like, a nice place to live, a

sense of purpose or meaning to life, a satisfying sex life, and being able to enjoy yourself” (p. 15). This statement seemed to augur well for the inclusion of some contextual focus and meso-systemic analyses. The aims of the book were stated as: increased knowledge, confidence, support network and quality of life for the individual as well as better adjustment, relationships and motivation for the future. The authors clearly stated that the book is primarily based on cognitive behavioural therapies (CBTs) and on Lazarus and Folkman’s theories of coping. It is divided into three sections: Basic information and advice on key aspects of living with HIV, Emotion focussed strategies and Problem focussed strategies.

The strongest section of the book is the first section which gives people good information about the nature of HIV, disease progression and prognosis, anti-retrovirals (ARVs) and the healthcare system. It emphasises the importance of ARVs to quality of life. Because developing and transitional countries have only 42% of the population in need with access to ARVs, the text’s utility is nation specific. The authors provide clear definitions of the medical terms, procedures and professionals that HIV positive people may encounter within the UK. The information is accessible and clear and this could assist in empowering individuals to better negotiate on their own behalf within the health system. Particularly clear sections include those on ARV side effects, the rights of patients, issues around disclosure, paediatrics and HIV and pregnancy and breastfeeding.

Other sections of the book cover issues such as CBT, defining and managing stress, coping styles, anxiety and depression, and mindfulness. In these domains, the authors are less effective, partly because of they use medical jargon, concepts and language, and partly because they over-summarise and over-simplify some complex domains. This simplification results in the treatment of topics such as death in a superficial manner that is less than helpful to the patient. The entire domain of mindfulness therapy is synthesised into 10 pages. This

amount would be appropriate for a description only, but is accompanied by text instructions for practice. The notion that this mindfulness précis could be utilised by the naïve practitioner is highly dubious. The broad brush approach also creates some unhelpful ambiguity. For example, in the section dealing with myths about HIV the following statement, “that you are a danger and that you will easily transmit the virus during sex” (p.132.), is cited as a myth. I am sure the authors intended the emphasis to be on the word ‘easily’ but to present this statement as emblematic of HIV myth is obfuscating.

From a community psychology perspective the individualistic focus of the book is problematic. The statistical reality that vulnerable populations have higher rates of STIs in general and that these populations tend to be less likely to have a ‘nice place to live, supportive partner and friends and a job or occupation they like’ is not addressed. Wider social issues linked to the neo-liberal dismantling of the welfare and industrial relations systems such as increased stigma and discrimination and enforced labour and compliance programs for people who lose employment (due to HIV diagnosis or other reasons) are not acknowledged or addressed. The focus on the individual ‘coping’ and ‘maintaining a positive attitude’ is problematic in this context. There is scant text devoted to how the individual can access wider social and government support although there is an appendix of agencies at the back of the text. Tackling the complex issue of how to increase one’s social support is also given inadequate coverage. The language of the book is quite complex and is pitched at secondary and possibly tertiary educated populations hence, may be of little utility to less educated individuals or those from a non-English speaking background.

The text provides complex information and could be seen as an early primer for the patient seeking information around diagnosis and some forms of psychological therapy. The text is most likely to be helpful to the naïve patient who has few psychological or emotional skills and who has just received an HIV diagnosis. It provides a

lot of information and a stepwise approach that, in the shock of diagnosis, may help the individual have a sense of what they are facing and that there are still options available to them.

Mental Health First Aid Manual  
Second Edition  
Betty Kitchener, Anthony Jorm and Claire Kelly  
2010  
Melbourne, Orygen Youth Health Research Centre

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Mental health first aid is the help offered to a person who may be developing a mental health problem, or who is experiencing a mental health crisis. 'Being prepared' is a sound strategy. Many people in the community learn First Aid, and regularly update their knowledge and skills, 'just in case' they might one day need to provide assistance to someone who is ill or injured, and keep them safe until professional treatment can be accessed. Similarly, it is wise to 'be prepared' by learning how to offer and provide mental health first aid until appropriate professional help is received, or until the crisis resolves.

The Mental Health First Aid Manual, Second Edition, is an updated and expanded version of the original Mental Health First Aid Manual (Kitchener & Jorm, 2002), which sold around 10,000 copies in Australia. It was also adapted or translated in thirteen other countries. While the manual was written to accompany a 12 hour Mental Health First Aid course, it is also a self-contained resource, primarily designed to enable members of the public, who may have little or no prior mental health knowledge, to assist someone who may be developing mental illness, or who may be experiencing a mental health crisis. The first edition is regularly used by a range of health professionals, as well as in the training of medical, nursing, pharmacy and paramedical students. It has also been used as a training resource by Divisions of General Practice. The updated second edition, being more comprehensive than the original, with twice the number of pages and an even stronger research base, is expected

to be even more useful as a training resource. It is based on five years of research, using Delphi expert consensus studies, to develop international mental health first aid guidelines. These guidelines can be accessed online at <http://www.mhfa.com.au/Guidelines.shtml>

For such a comprehensive resource, the manual is surprisingly user-friendly. Divided into three main sections, the sub-headings and colour-coded format ensure that information can be located fast. The content is easy to read and clearly explained.

Section 1 defines mental health and presents information relating to the epidemiology and impact of mental illness in the Australian community. It also reports the spectrum of interventions, from prevention and early intervention to treatment and supports. The need for people in the community to be better informed about mental health problems is also covered.

Common myths and misunderstandings such as: 'only weak people have mental health problems' and 'people who have mental illnesses are dangerous' are discussed, as well as the impact of stigma and discrimination on the help-seeking behaviours of people with mental health problems. For instance, they may feel ashamed and try to hide their problems from family, friends, teachers or colleagues. Because of all the misconceptions in relation to mental illness, they may internalise the stigma and believe that the negative things that are said about people with mental health apply to them. They may be afraid to seek treatment due to concerns about what others may think if they find out. The authors cite the 2007 National Survey of Mental Health and Wellbeing, an Australia-wide community survey of 8,841 people aged 16-85, living in private dwellings, which found that one in five had a common mental illness (depression, anxiety and/or substance use disorder) at some time in the 12 months prior to the survey. Furthermore, only 35% of the people who had a mental illness in the previous year had received professional help. Section 1 also includes The Mental Health First Aid Action Plan. Just as with First Aid for physical illness

and injury, where the memorised mnemonic DRABC(D) – standing for Danger, Response, Airway, Breathing and Compressions (Defibrillation) - helps to remind us of the best plan of action in an emergency, so the acronym ALGEE enables us to remember the plan of action to assist a person who is experiencing a mental health crisis, or who may be developing mental health problems. A stands for ‘Approach, Assess and Assist’ the person with any crisis; L for ‘Listen’ non-judgmentally; G for ‘Give’ support and information; E for ‘Encourage’ the person to get appropriate professional help; and E for ‘Encourage’ other supports.

Section 2 relates to First Aid for developing mental health problems. Under the headings of Depression, Anxiety, Psychosis, and Substance Misuse, information is provided about types, risk factors, interventions, importance of early intervention, crises associated with the disorder, and helpful resources. A Mental Health First Aid Action Plan (in the form of ‘ALGEE’) applies for each, with additional, disorder-specific information on ‘what to do’ and ‘what not to do’. Having the same ‘Action Plan’ for each disorder makes it easier to remember what to do, as only the disorder-specific information needs to be separately memorised.

Section 3 covers First Aid for mental health crises, including ‘Suicidal Thoughts and Behaviours’; ‘Non-suicidal Self-injury’; ‘Panic Attacks’; ‘Traumatic Events’; ‘Severe Psychotic States’; ‘Acute Effects of Alcohol Misuse’; ‘Acute Effects of Drug Misuse’; and ‘Aggressive Behaviours’.

Just as we never know when or if we will ever be called on to use our First Aid knowledge and skills in the event of a physical illness or injury, so we never know when or if we will find ourselves in a situation where we need to utilise our Mental Health First Aid knowledge and skills. Professional assistance is not always immediately available in an emergency.

The aims of every First Aid program are to preserve life; prevent further harm; promote recovery; and provide comfort. If we truly believe that mental health is at least as important as

physical health, then we need to ‘be prepared’ and ensure that a Mental Health First Aid Manual is sitting right alongside our other First Aid Manual on the bookshelf, at home and at work.

Kelly, C., Kitchener, B., & Jorm, A. (2010). *Youth mental health first aid: a manual for adults assisting young people* (2<sup>nd</sup> ed.). Orygen Youth Health Research Centre, Melbourne, Australia. ISBN: 9780980554144.

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First aid is well-known as a method of providing the general public with skills to assist injured people before professional medical treatment can be obtained. First aid training has traditionally not incorporated mental health issues despite the increasing rates of mental health issues within the community. It is on this basis that Mental Health First Aid training has been developed to train non-mental health professionals to provide help to a person developing a mental health problem or experiencing a mental health crisis. As with first aid for injured people, this is provided until appropriate professional help is received or until the crisis resolves. *Youth mental health first aid: A manual for adults assisting young people* ("the manual") is used in conjunction with the Mental Health First Aid Training Program, a 12 hour course, to train adults who have frequent contact with young people, for example, parents and guardians, school staff, sports coaches and youth workers.

The first edition, published in 2002, has been widely read in Australia and adapted or translated in 13 other countries. The authors report that previous editions of the manual have been widely used by health professionals, including during training of students in medicine, nursing and paramedicine as well as used for training purposes by Divisions of General Practice. The second edition of the manual is based on mental health first aid guidelines developed with the consensus of expert panels of mental health consumers, carers and professionals and incorporates up to date Australian statistical information and the most recent evidence in relation to treatments and services available for young people.

The manual takes the reader on a comprehensive journey through the developmental changes associated with adolescence before proceeding to describe in detail the most common mental health problems experienced by young people. Care has been taken to clearly describe how behaviours and features of mental health problems can be distinguished from typical adolescent behaviour, whilst acknowledging the interrelationship between adolescence and mental health problems. Each chapter on mental health problems includes definitions, signs and symptoms, risk factors, interventions, mental health first aid action plans as well as current resources (including books, websites and help lines) relevant to the mental health problem with a specific focus on adolescents. The last section of the manual provides first aid for particular mental health crises, including suicidal thoughts and behaviours, severe psychotic states, effects of drug misuse and aggressive behaviours.

Throughout the manual the role of the first aider is clearly defined to place boundaries around it, particularly stressing the importance of early intervention and response but also the necessity for appropriate assessment and interventions from appropriately trained and experienced professionals. The manual alerts the reader that young people may not always wish to seek assistance and provides practical advice for the first aider in responding to that situation.

The tone of the manual is respectful of the needs and rights of young people, encouraging the first aider to offer choices where possible, to respect the right of the young person to make decisions about treatments as well as strategies to encourage open and effective communication. Equally the manual outlines the responsibilities of the first aider in taking action if a young person is deemed at risk of harm, including mandatory reporting of abuse, and seeking emergency treatment for a young person at risk. The manual also explains the nature of professional support provided by a range of professional workers to clearly assist in the help seeking process for young people, whilst also ac-

knowledging the potential benefit of some self-help strategies of interest to young people (such as art as a form of expressing feelings). Early intervention is stressed throughout the manual as the priority – in recognising signs and symptoms early and encouraging young people to seek help prior to crises developing.

In this way the role and responsibilities of the first aider are well defined with the aim of ensuring the adult has adequate information to make well informed decisions about actions to support the young person, clear information to assist in understanding the experience of young people in a mental health crisis and recognition of the difficulties in providing appropriate support at times. Critical ethical issues such as the right to privacy of the young person and their rights to make decisions about health care are covered. Considerable effort is made to encourage adults assisting young people to enhance their listening skills to ensure they listen respectfully and non-judgementally (“You need to set aside your beliefs and reactions in order to focus on the needs of the person you are helping; their need to be heard, understood, and helped”, p. 37). Communicating effectively with young people from different cultural backgrounds is also considered with some guidance about developing understandings in relation to cultural beliefs around mental illness in order to be culturally competent when providing mental health first aid.

The voice of young people is heard throughout the manual by the inclusion of art work and accompanying statements to bring to life the experience of mental illness and feelings associated with it. Some of the artwork describes the benefits of help seeking, setting out the positive changes that occurred after help was sought and obtained (“My drawing represents what I saw then, when I was 14, before I was helped, and what I still see now and again” Jess, aged 16, p. 56). Accordingly the reader is provided with greater insight into mental illness, particularly as it relates to young people as well as validating the important role of the first aider in assisting young people.

Overall, the manual fills a gap in the provision of succinct, evidence-based and up-to-date information about adolescent development and mental health problems and the most appropriate responses from a first aid perspective. It no doubt plays a role in breaking down stigma relating to mental illness in young people and encouraging dialogue with young people through encouraging adults to develop their own awareness and skills to respectfully assist at the earliest possible time to prevent mental health crises developing. Given that “half of all people who ever develop a mental illness will have had their first episode prior to the age of 18” (p. 11) the need for such a resource focusing on the adolescent period is evident.

Seymour Sarason Obituary  
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Psychologists and educators across the world mourn the death of a visionary giant in both fields and a beloved mentor, Seymour B. Sarason, professor emeritus of psychology at Yale University. He died on Thursday, January 28, 2010 at age 91 in New Haven.

Called father of community psychology, dean of educational reform, and ground-breaking leader in the field of mental retardation, Sarason joined the Yale faculty in 1945 and taught generations of students for five decades until his retirement in 1989. At that time, his work was celebrated in a special issue of the *American Journal of Community Psychology* (1990, volume 3). Enormously prolific, he published 45 books and 66 articles in diverse fields impacting human development (see <http://seymoursarason.com>). His last book *Centers for Endings: The Coming Crisis in the Care of Aged People* written about his experiences in residential care communities, will be published this year

In *Psychology in Community Settings* (1966) co-authored with Levine, Goldenberg, Cherlin, and Bennett, Professor Sarason defined the field of community psychology. Written about the Yale Psycho-Educational Clinic, which he founded and directed from 1961-1970, this work ushered in a paradigm shift for clinical psychology, engendering much controversy.

Earlier an expert in mental retardation and atypical development (*Psychological Problems in Mental Deficiency* now in its fourth edition, 1969), test anxiety (*Anxiety in Elementary School Children* 1960), and projective tests (*The Clinical Interaction* 1954), Sarason turned away from commonly held assumptions. He urged psychology to partner with education, instead of medicine and the medical model (*Psychology Misdirected* 1981; *American Psychology & Schools* 2001). He shifted thinking from deficit analysis to nurturing potential, from treatment to

prevention, from seeing problems in individuals to the role of social settings, from expert to collaborative partner, and from individual change to social change.

With remarkably vivid examples, Professor Sarason gave us a conceptual frame and language for understanding the qualities of social settings that hinder human development and the challenges that confront social and institutional change, sensitive to historical context (*The Culture of the School and the Problem of Change* printed in 1971, 1982, and 1996). Sarason opened new lines of study, such in *The Creation of Settings and Future Societies* in 1972, *The Psychological Sense of Community: Prospects for a Community Psychology* in 1974, and *Human Services and Resource Networks* in 1977. And he called us to social action in schools, in communities, and in society at large.

An incisive critic of educational reform, Sarason's contributions remain seminal. School culture, productive learning, teacher preparation, political governance, parent involvement, and charter schools are among the issues he addressed with clarity and wisdom in too many books to name here. He spoke his mind freely, issuing *Letters to a Serious Education President* twice in 1993 and 2006. His most recent collaboration was with physicist Stanislaw Glazek in a book called *Productive Learning: Science, Art, and Einsteins Relativity in Educational Reform* published in 2007.

His books were classics and read like novels, as he was a keen social critic who wrote fully in his own voice. He published his autobiography in 1988 (*The Making of an American Psychologist*) and a novel *St. James and Goldstein at Yale* in 2005.

Beyond the remarkable legacy left in his written work is the impact he had on his students, his colleagues, a community of individuals who sought his counsel until his dying days, and a legion of schools and programs that benefited from his analysis – across the country and worldwide. With his

door always open, his stance ever welcoming, Sarason created that context for productive learning about which he wrote. And all who came into contact with him learned beyond their imagination, put into action programs that developed human potential, and fell in love with his kind and caring ways.

Sarason earned his undergraduate degree from Rutgers (then the University of Newark) in 1939. His Ph.D. in clinical psychology was awarded from Clark University in 1942. Among many honors, Professor Sarason was the recipient of three honorary degrees and six distinguished contributions awards, including Distinguished Contributions to Community Psychology (Society for Community Research and Action [SCRA]) and the Lifetime Contribution to the Public Interest Gold Medal from the American Psychological Foundation. The Seymour B. Sarason Award for Community Research and Action was established in 1993 by SCRA and the American Psychological Association to recognise individuals working in the conceptually demanding, creative, and groundbreaking tradition of Sarason.

His wife of 50 years, Esther Kroop Sarason predeceased him in 1993. He leaves a daughter Julie Sarason, her husband Paul Feuerstein, a grandson Nathaniel, a brother Irwin Sarason and sister-in-law Barbara, a brother-in-law Dr. Irving Kroop and wife Eugenia, and companion Irma Janoff Miller.

## Preparation, Submission and Publication of Manuscripts

*The Australian Community Psychologist* publishes work that is of relevance to community psychologists and others interested in the field. Research reports should be methodologically sound. Theoretical or area review papers are welcomed, as are letters, brief reports and papers by newer contributors to the discipline. Contributions towards the four sections of the journal are sought.

*The Australian Community Psychologist* is published twice per year and online and is available via the website of the Australian Psychological Society's College of Community Psychologists' page (<http://www.groups.psychology.org.au/GroupContext.aspx?ID=883>).

### Articles

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### Research Reports

This section is for the publication of empirical research reports relevant to community psychologists. They are between 4,000 and 10,000 words, including all tables, figures and references.

### Practice Issues

This section publishes individual manuscripts and collections of manuscripts which address matters of general, professional and public relevance, techniques and approaches in psychological practice, professional development issues, and professional and public policy issues.

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The journal publishes book reviews of up to

1,000 words. Books reviewed relate directly to the major areas of practice in community psychology.

### Review and Publication of Manuscripts

The acceptable word processing programme format is Microsoft Word. All manuscripts are to be submitted electronically to the:

Editor

Lauren Breen

email: [l.breen@ecu.edu.au](mailto:l.breen@ecu.edu.au)

If authors experience any difficulty with electronic submission, hard copy materials together with a disc copy should be sent to:

Dr Lauren Breen

Social Research Research Centre

School of Psychology and Social Science

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270 Joondalup Drive

JOONDALUP WA 6027

Australia

All contributions, including book reviews are handled by an appropriately qualified Associate Editor and all contributions are blind-reviewed.

Articles submitted for review must be original works and may not be under consideration elsewhere.

It is a condition of publication that authors assign the copyright of their articles to the Australian Psychological Society.

All manuscripts for consideration for publication in *The Australian Community Psychologist* must be formatted according to the instructions for authors below.

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The following constitutes advice to contributors that is relevant generally to all journal sections.

*Every submission must include:*

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*Manuscripts should be arranged as follows:*

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Tables and figures should be placed in the correct position within the body of the text.

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# The Australian Community Psychologist